CITY OF CAPE TOWN

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ANNUAL REPORT

OF THE

MEDICAL OFFICER OF HEALTH

THE STAFF OF ASCLEPIOS

Asclepios the god of medicine, was the son of Apollo and Coronis. He was killed with a thunderbolt from Zeus because Pluto complained that through his efforts Hades was being depopulated. At Apollo's request, after his death, he was placed among the stars. His children included HYGIEIA and PANACEA. He is normally represented as an old man with a beard, and his main attribute is a staff with a serpent coiled around it. This has become the symbol of Medicine.

These two symbols, the serpent and the staff, have different interpretations and their mythological assessments point to various origins. The serpent embodies the destructive and life giving forces of water and the sun. The serpent of Asclepios was the protector of medicinal springs. The snake was also held to symbolise the unconscious side of man. The annual shedding of skin represents the restoration of health following a severe disease.

The staff, too, has had various significances attached to it. Since it was used by travellers, it suggested the willingness of the physician to travel long and wearisome journeys to help and cure the sick. It represents the tree of life, and, as a phallic symbol, it contains the idea of creativity. Probably most important is the interpretation of the staff of Asclepios embodying both elements as a symbol of harmony and unity towards which the sick could turn in their hour of need.

CITY OF CAPE TOWN

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ANNUAL REPORT

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MEDICAL OFFICER OF HEALTH

REPORT OF THE MEDICAL OFFICER OF HEALTH

OF THE CITY OF CAPE TOWN

FOR THE YEAR 1976

CONTENTS

TABLES

These apply to the City of Cape Town (including the B.A.A.B. areas of Langa and Guguletu and its residents unless otherwise specified.

THE CORPORATION OF THE CITY OF CAPE TOWN

REPORT OF THE MEDICAL OFFICER OF HEALTH

FOR THE YEAR 1976

HIS WORSHIP THE MAYOR, ALDERMEN AND COUNCILLORS
OF THE CITY OF CAPE TOWN

Ladies and Gentlemen

It is with pleasure that I present my second Annual Report concerning health conditions in the City of Cape Town, together with an account of the work conducted by the City Health Department during the year 1976. For practical purposes this is really my first full Annual Report since my tenure of office did not commence until the end of 1975. I have felt that an Annual report, such as this, should cater for three categories of reader; firstly, those who may wish to acquire a brief overall picture of the situation, secondly; those with a deeper interest, but who may well be daunted by the necessity to peruse in detail many tables of statistics, and finally, the statisticians themselves. This report has hopefully set out to serve the needs of all three groups. Some of the more important facts contained in this report include the following; (some of which are tabulated in Table I.I):—

AREA

The City was enlarged by the incorporation of Mitchells Plain (some 1 824 hectares).

TOTAL POPULATION

This is estimated to have increased to 842 620 (253 570 White, 477 470 Coloured, 100 530 Black and 11 050 Asian).

SOCIAL AND ECONOMIC CONDITIONS

For the first time civil disorder broke out in the Coloured and Black townships in the middle of the year. These disturbances subsided in the Coloured townships after a couple of months, but simmering unrest continued in the Black townships until the end of the year. These conditions posed many problems for the Department and to maintain clinic services and preserve environmental health conditions while protecting staff from death or injury, and buildings vehicles and equipment from destruction or damage, became priority day to day objectives over these troubled months. A remarkable degree of success was achieved in this direction. Two buildings were wholly destroyed and others suffered a varying amount of damage, but no vehicles were lost,and no health personnel were killed or injured. At a rough estimate total clinic figures fell in the Coloured areas by about 25^{0}/o during the worst months, but were compensated for by a marked rise in attendances over the last two months of the year. In the Black areas figures were not so good and various makeshift arrangements had to be made on the periphery and outside the townships in order to keep services going. The courage and unflinching devotion to duty of our Coloured and Black staffs, all of whom were resident in the troubled areas, cannot be too highly praised.

NOTIFIED LIVE BIRTHS

These numbered 19 641 (3 186 White, 12 076 Coloured, 4 115 Black and 264 Asian), a decrease of 258 over 1975 (102 fewer White, 264 fewer Coloured, 84 more Black and 24 more Asian) which reflected a fall in the overall birth rate from 24,3 to 23,3 per 1 000 population.

STILL BIRTHS

These numbered 322 compared with 317 in 1975.

ILLEGITIMACY

Illegitimate births increased from 7 327 in 1975 to 7 508 in 1976 and accounted for 36,2^{0}/o of all births. Illegitimacy rates for Whites in Cape Town (10,5^{0}/o of all Births) and in Washington, U S A (12,9^{0}/o) and for Blacks in these two cities (58,2^{0}/o and 57^{0}/o respectively) are remarkably similar.

DEATHS

Total corrected deaths numbered 6 747 compared with 6 192 the previous year. The slight increase in White deaths was general (degenerative heart disease, senility or ill defined causes and malignant neoplasms continued to account for 60^0/o of deaths). Coloured deaths increased slightly and once again showed a much wider spectrum of causes than White deaths (malignant neoplasms and cerebrovascular disease moved up in rank; senility or ill defined causes and pneumonia dropped in rank; and all these causes, together with degenerative heart disease, accounted for 54^0/o of deaths compared with 59^0/o in 1975). Black deaths also increased slightly and showed a wide spectrum of causes (pneumonia and gastro-enteritis increased in importance while malignant neoplasms and pulmonary tuberculosis fell in rank; these conditions, together with senility or ill defined causes, and homicide, accounted for 60^0/o of deaths compared with 50^0/o in 1975).

INFANT MORTALITY

The number of deaths was lower in 1976, and infant mortality rates fell to the lowest ever recorded, for Whites, Coloureds and Asians. (10,4; 31,6 and 3,8 deaths per 1 000 live births respectively).

In Blacks however there were 325 such deaths in comparison with 238 in 1975 which reflected an increase in Infant Mortality from 59 to 79 deaths/1 000 live births. This increase was largely due to an increase in post neo-natal mortality, primarily due to gastro-enteritis and pneumonia. I feel there is a marked connection here with the severe economic depression, and consequent malnutrition.

MATERNAL DEATHS

There were nine deaths (5 Coloured and 4 Black) of which 8 were due to abortion and one to childbirth.

DEPARTMENTAL RE-ORGANISATION

The complete re-organisation of the Department's Promotive and Preventive Services from the basis of a number of self-contained Branches, eg Maternal and Child Welfare Branch, Tuberculosis Branch, Venereal Diseases Branch etc., into a comprehensive preventive service to co-operate with the curative services provided by the Provincial Hospitals Department continued. (Re-habilitative services have yet to be developed on a broad scale and legislative indications at the time of writing are that the City Health Department will be closely involved in this undertaking in the not too distant future).

This re-organisation entails the conversion of clinics to the polyclinic principle and the in-service training of medical, nursing, administrative, and clerical staff in the new concept. In this connection, the Heideveld Polyclinic had been set up as a pilot scheme. From the outset, the re-organisation was enthusiastically accepted by all concerned, and the obvious advantages of a more complete service to the public, fuller utilisation of premises, and also the fuller utilisation of the skills and training of all professional staff were realised.

During the year our centres at Silvertown, Lavender Hill and Kensington were converted to poly-clinics and this ensured provision of comprehensive services to some 240 000 Coloured municipal residents by the end of 1976. Remaining areas continued to be served by the old fragmented Tuberculosis, Venereal Disease and Maternal and Child Welfare organisation.

The thrust of change is towards precise epidemiological assessment of the health status of well-defined sub-communities of the Municipal population, and the tailoring of Promotive and Preventive Health services towards their Health needs. Accurate planning for the expansion of health services and valid evaluation of the work of this Department are also dependent on an accurate data base and apart from redefining data collection it is hoped to computerise much of the collation and analysis in the future.

FAMILY PLANNING

Attendances increased over 1975 and it is estimated that about one in twenty five White and one in every four Coloured women of child bearing age (15–49 years) are attending City Council Family Planning clinics.

ANTE-NATAL CARE

Attendances continued to fall due to many factors including the decrease in deliveries booked with private midwives, the increased provision of services by the Provincial authorities and the decrease in the number of pregnancies (hopefully brought about by Family Planning).

CHILD WELFARE

Total attendances declined somewhat, mainly because fewer births are being Notified. About 77% of White and 88 1/2% of other Notified births resulted in new attendances at City Health Department clinics before the infant attained one year of age. Immunisation programmes continued to receive priority and the various full-cream and skim-milk powders available at the clinics proved a valuable aid to proper infant nutrition.

GERIATRICS

The introduction of a thorough geriatric screening service has filled a long felt need and is an innovation which will be expanded steadily as resources permit.

HOME VISITING

This continues to be a vital aspect of the promotive and preventive personal health service with 175 218 such visits being recorded in 1976 (the decrease over the 1975 figure of 181 648 being ascribed largely to fewer visits in connection with births, ante-natal cases, private midwives and immunisation defaulters and also to the difficulties caused by civil unrest).

HEALTH EDUCATION

Emphasis was again placed on the in-service training of all professional staff of the Department in this field to maximize the impact of our small Health Education staff.

TUBERCULOSIS

Total Notifications of all forms of this disease in local residents fell from 2 177 in 1975 to 2 013 in 1976, but imported cases in residents of less than six months standing increased from 456 to 622. It is estimated that the approximate number of Notified cases of Tuberculosis (all forms) still requiring chemotherapy at the mid-point of the year per 10 000 population was for Whites 3,8; Asians 7,2; Coloureds 33,9 and Blacks 232,4.

Notification rates of Pulmonary Tuberculosis in 1976 were 0,09 (Asian); 0,21 (White); 1,94 (Coloured; and 9.87 (Black) per 1 000 population.

Tuberculosis remains the most important single communicable disease problem in Cape Town and there were 168 Tuberculosis (all forms) deaths in 1976 as there were also in 1975.

SEXUALLY TRANSMITTED DISEASES (S.T.D.)

The number of new attendances at clinics rose to 15 969 from 15 748 the previous year. Only 12 985 of these were confirmed as cases of sexually transmitted diseases however compared with 13 017 in 1975. Acquired Syphilis cases increased by 28 and Gonorrhoeal infections decreased by 383; other S T D cases increased by 284. Non-venereal diagnoses increased from 2 731 to 2 984. (NB "New cases "includes reinfections). Congenital syphilis cases showed a disquieting increase from 36 cases in 1975 to 75 cases in 1976.

NOTIFIABLE DISEASES (other than Tuberculosis):

Cerebrospinal Fever –there were 120 cases in 1976 compared with 72 in 1975. The incidence rates per 100 000 population for 1976 (and 1975 in brackets) were for Whites 4,3 (4); Coloureds 17 (13) and Blacks 25 (4). The death rate per 100 000 population per year increased markedly from 0,61 in 1975 to 2,73 in 1976.

Viral Hepatitis – There were 102 cases and 3 deaths compared with 99 cases and 4 deaths in 1975.

Scarlet Fever – There was a minor epidemic of this condition (and also of streptococcal sore throat). There were 100 persons Notified with Scarlet Fever (93 of them White) compared with 13 in 1975.

Typhoid Fever – There were 9 cases in 1976, the lowest number since 1969.

Other – There were 18 cases of ophthalmia neonatorium, 15 of Whooping Cough, 9 of Diphtheria, 6 of Acute Poliomyelitis, 2 of Tetanus, 2 of Leprosy (imported), 1 of Puerperal Fever and 1 of insecticidal poisoning.

NON-NOTIFIABLE COMMUNICABLE DISEASES

Measles. Despite the limited immunisation programme of the past few years there were 626 admissions to the City Hospital (352 local and 274 out of city cases) in 1976 compared with 550 (268 local and 282 out of city cases) in 1975. Thus local admissions increased by 31% from 1975 to 1976. There were 24 deaths in the City Hospital (3,8% of measles admissions) and corrected registered deaths of municipal residents (whether admitted to City Hospital or not) totalled 34 (compared with 27 in 1975).

Influenza, Bronchitis and Pneumonia. No estimate of the morbidity occasioned by these conditions can be made but together they caused 710 deaths in 1976 compared with 550 in 1975 (an increase of 29%).

Gastro-enteritis etc. Diarrhoeal diseases killed 264 persons in 1976 compared to 213 in 1975 (an increase of 24%) with the major increase being in the Black group.

CITY HOSPITAL. There was a gross total of 1 777 admissions in 1976 compared with 1 863 in 1975. The biggest fall in disease-specific daily bed occupancy between these two years was from 11,7 to 2,2 for Black/Coloured/Asian Typhoid cases (there was a Typhoid epidemic in a nearby area in 1975).

DENTAL SERVICES. While overall attendances were lower in 1976 this was due to the closure of certain clinics during the civil unrest and to the gradual return to the State Health Department of its responsibility for the Dental Health of Coloured school children. Allowing for these factors, attendances showed a slight increase. It is noteworthy that the Department's Dental service is the oldest in the country having been in operation for over 40 years.

OTHER SERVICES. Due to the marked decrease in the utilisation of the Washhouses these anachronistic facilities were closed down during the year.

ENVIRONMENTAL HEALTH

Health Inspection. The total number of inspections fell from 143 934 in 1975 to 138 472 in 1976, largely because of the freezing of certain posts as part of the economy drive, and because of the civil unrest in certain areas.

Air Pollution. It became apparent during 1976 that real progress was being made in the control of visible atmospheric pollutants; it also became apparent that the major problem of the future is going to be that of the motor car.

The first Smoke Control Zone Order became effective on 1976–02–14 and only three visits involving smoke were necessary to the end of the year. Some of the most difficult complaints to rectify are caused by odours, fumes or dusts where remedies are not easy to apply, and in some cases cannot be applied at all. These shortcomings in the legislation are recognised by Local Authorities and the State, but it is not proposed to make changes until the economic climate improves.

Water Supply. This posed no health problems during the year.

Food Control. The milk shortage of 1975 was replaced by a surplus in 1976, yet consumption fell in the latter year. The incidence of Brucellosis is being estimated with a view to the eradication of this disease from the Western Cape. Further strides have been taken as regards Tuberculosis eradication.

Control over the Abattoir remained with the Town Clerk's Department. Unsound meat and other foodstuffs were condemned where necessary and food samples analysed to detect infringements of Act 54 of 1972.

Control of Trading. 5 296 applications to trade were dealt with in 1976 compared with 4 444 in 1975.

Housing. The Housing crisis escalated alarmingly in 1976 and it must be emphasised that the absymal living conditions of so many families, both in the Municipal area and in contiguous areas, poses a real threat to the Public Health of the whole region. The Coloured waiting list for council houses grew by more than twice the number of families actually housed from this list and unless vast amounts of finance are made available (the indications are that this will be the case) the situation can only worsen. The provision of site-and-service schemes has opponents who argue that these ensure the development of permanent slums but this need not necessarily be so, given due attention to the provision of essential services, security of tenure, core housing and planned financial assistance with owner-building of homes.

Sewerage. The vast majority of premises in Cape Town are connected to the water-borne sewerage system but pail removals are a necessary evil still in some areas.

Surface Sanitation and Stormwater drainage. In general these remain satisfactory throughout the bulk of the Municipal area except in certain areas where stormwater enters the sewers, and causes flooding in periods of exceptionally heavy rain.

Pest Control. Staff remained fully occupied in controlling the rodent, mosquito and cockroach populations of Cape Town.

ADMINISTRATION

The economic crisis became acute in 1976. It was realised that intensive efforts to economise in all fields of activity and at the same time greatly increase the productivity of staff, were absolutely essential. These problems were attacked on a detailed departmental basis. Branch heads and other senior key personnel were motivated and required to set up a job survey and productivity assessment project for every single post under their jurisdiction, required levels of saving were explored in detail and means indicated. Results were monitored on a month to month basis and where necessary issues were re-examined and re-assessed. It was unfortunate that all this was necessary during a time of expansion of services in the Comprehensive Preventive service concept. Nevertheless, how effective these measures proved to be is illustrated by the fact that the increase in actual expenditure over 1975 was held down to 5,72% overall. (A saving of 12,33% over the original estimated annual expenditure for 1976).

ACKNOWLEDGEMENTS

I record with appreciation and thanks the loyal support and assistance so willingly given to me by the members of my staff. In this context a special word of thanks to all those who have collaborated in shaping the new format of this Annual Report. I wish also to thank Heads of other Council Departments and their officials for their co-operation and assistance during the year.

To the Chairman and members of the Amenities and Health Committee and to all other Aldermen and City Councillors, I also offer my thanks for their consideration and support at all times.

To the Municipal Service Commission, I am extremely grateful for their courtesy, helpfulness and understanding in regard to staff matters.

To Dr N Le Roux, Regional Director State Health Services, Western Cape, and his deputy Dr L Been, sincere appreciation of their helpful co-operation and understanding in all matters where our mutual interests met.

To Professor L S Smith, Director of State Health Laboratories, and expression of genuine gratitude for his always excellent advice and assistance so freely given.

To Professor I Spencer, Department of Community Medicine, University of Cape Town, with whom we have been intimately involved in training programmes an appreciation of his willing co-operation and assistance at all times.

To Professor D Davey, Head of Department Obstetrics and Gynaecology, University Cape Town, sincere gratitude for his helpful co-operation and advice in all matters of common interest.

To Dr J Smith, Medical Superintendent Day Hospitals Organisation, gratitude and appreciation for helpfulness and co-operation in the many areas in which our respective functions correlate.

To Professor S Saunders, Head of Department of Medicine, University Cape Town, a special word of thanks for his friendly co-operation and the gratifying knowledge that the invaluable help of his Department can be called upon whenever the need arises.

Last, but not least, to the Ladies and Gentlemen of the Press, and the South African Broadcasting Corporation, many thanks for their accurate, objective and informative reporting of matters relating to the health of the public which were of concern to the citizens of Cape Town throughout the year.

Yours faithfully

R J COOGAN
LRCS, LRCP (Irel), DPH, LM, FRSH.
MEDICAL OFFICER OF HEALTH

City Health Department
Libertas
Hertzog Boulevard
Foreshore
CAPE TOWN
8001

SECTION I

ADMINISTRATION, FINANCE AND STAFF

Because of the difficult financial climate which prevailed over the past three years, the call for greater productivity and the need to effect economies were brought sharply into focus by the directive of the Central Government to local authorities to achieve savings of at least 10% on planned expenditure on refundable health services.

Initially a reduction of 10% on budget seemed over-optimistic as due cognizance had already been taken of the cost escalation phenomenon over the past few years and continuous efforts had been made to control the insidious effects of inflation.

In the formulation of a policy for achieving still greater economies, a series of meetings were held with senior staff and other key personnel. The task was to examine and evaluate every possible area of savings and to introduce a programme for improving productivity by the better utilization of existing resources. Targets were clearly defined, and a financial system was introduced for proper performance evaluation and for remedial action to be taken in areas where anticipated savings were not forthcoming.

The measures for achieving economies were aimed at a target saving of 12% on the 1976 budget. However, the curtailment of expenditure came at a time when the Department was committed to change to comprehensive promotive and preventive health services in line with the declared policy of the State Department of Health. At the end of 1975 five community health centres had already been introduced in the municipal area and the centres planned for 1976 had to be undertaken on a fiscal policy of offering a more efficient and effective service without incurring cost increases. Particular attention was paid to staff and work distribution, rationalisation and better utilisation of buildings and equipment, and the maximisation of other resources such as transport and patient records.

Of paramount importance was the creation of an awareness amongst all levels of staff of the need to achieve economies, and the promotion of attitudes of personal involvement in increased productivity. Half way through the year savings amounted to 14,5% of budget; this was most encouraging and indicated maximum co-operation and effort throughout the Department.

A long standing industrial dispute between the Council and the South African Association of Municipal Employees ended in October at a Conciliation Board when agreement was reached on salary and wage increases for all municipal employees; this resulted in a 10% increase in the anticipated revised annual salary and wages bill for my Department.

Despite this additional unforeseen expenditure, the economy campaign resulted in an overall saving on the original estimated annual expenditure of 12,33%. Actual expenditure compared to the previous year increased by 5,72% and this related most favourably to the national inflation rate of over 12%, especially as the increase was attributable mainly to uncontrolled expenditure such as the salary and wage increases, and interest and redemption charges. (See Table I.II).

Due largely to the cut back in capital expenditure, no new projects were undertaken in 1976. Capital Expenditure for the year totalled R83 507 and was incurred mainly on motor vehicles, replacement of the City Hospital incinerator, and air pollution equipment. Various minor alterations were made to existing clinics as part of the programme of change to community health centres.

Since nearly 70% of the Department's expenditure relates to salaries, wages and allowances, the major area for achieving economies lay in increased productivity. However, to achieve this simply on a basis of leaving vacancies unfilled could in itself be counter-productive, and a plan was formulated for the filling of vacancies only after the need for each post had been critically examined and evaluated. This programme proved most successful and out of an establishment of 1 109 at the end of the year, 165 posts were vacant.

STAFF ESTABLISHMENT AS AT 31 DECEMBER 1976

MEDICAL

R J COOGAN,	L R C S., L R C P (Irel)., D P H., L M., F R S H.	Medical Officer of Health
M A CHAIMOWITZ,	M B., Ch B., D P H.	Deputy Medical Officer of Health
M E E POPKISS,	M B., Ch B., DCM.	Assistant Medical Officer of Health
R A SPIRO,	M B., Ch B.	Principal Medical Officer
A E TIBBIT,	M B., Ch B., D P H.	Principal Medical Officer
A J WILSON,	M B., Ch B.	Principal Medical Officer
L B BLUMENTHAL,	M B., Ch B.	Senior Medical Officer
N WALKER,	M B., Ch B.	Senior Medical Officer
S SANDERS,	M B., Ch B.	Senior Medical Officer
J L K MARAIS,	M B., Ch B.	Medical Officer
G R F MASEY,	M B., Ch B.	Medical Officer
F R PRINSLOO,	M B., Ch B., B Sc.	Medical Officer
J I RENNIE	M B., Ch B.	Medical Officer
M ZABOW,	M B., Ch B.	Medical Officer
T F NEWMAN,	M B., Ch B., D P H.	Medical Officer
N A MURISON,	M B., Ch B.	Medical Officer
M N HOFFMAN,	M B., Ch B.	Registrar in Community Med
J D POWER,	B Sc., M B., B S (Lond)., M R C P (Lond).	Registrar in Community Med
Vacant		Assistant Medical Officer of Health
Vacant		Medical Officer

ADMINISTRATION

J H COOMER,	I M T A., (S A).	Administrative Officer
A B R LOVE		Assistant Administrative Officer
C E BAILEY,	A I A C	Principal Administrative Assistant
SENIOR ADMINISTRATIVE ASSISTANTS		5
SENIOR CLERKS		8
CLERKS		16
PERSONAL ASSISTANT TO MEDICAL OFFICER OF HELATH		1
SECRETARIAL ASSISTANT		1
PRINCIPAL WOMAN ASSISTANT		1
SENIOR WOMAN ASSISTANTS		6
WOMAN ASSISTANTS		9
SHORTHAND TYPIST		1
WORKS CLERICAL ASSISTANTS		1
OFFICE ATTENDANTS		2
CARETAKER/CLEANER		1
LABOURER		1

AIR POLLUTION CONTROL

B D OXLEY,	O N C., (Mech Eng), H N C., (Elec Eng), A M I., SA Mech E.	Air Pollution Control Officer
SMOKE CONTROL INSPECTORS		2

CITY HOSPITAL FOR INFECTIOUS DISEASES

T J MALHERBE,	M B., B S., D T M & H., T D D.	Medical Superintendent
S A FISHER,	M B., Ch B.	Deputy Medical Superintendent
J S FLETCHER,	M B., Ch B.	Medical Officer
D H ROY,	M B., Ch B.	Medical Officer
J SCHWERSENSKI,	M B., Ch B.	Medical Officer
G H MOLLER,	M B., Ch B.	Medical Officer
M O'SULLIVAN,	Certs. S A Nursing Council (Gen., Midwif & T B)	Matron
D M BARRY,	Certs S A Nursing Council (Gen & Fever)	Assistant Matron
J M KRIEL	Certs S A Nursing Council (Gen & Fever)	Assistant Matron

D C UNGER,	Chemist & Druggist Diploma	Principal Pharmacist
PHARMACISTS		2
SISTERS		44
STAFF NURSES		33
NURSING ASSISTANTS		103
CLINIC ASSISTANT		1
RADIOGRAPHER		1
OCCUPATIONAL THERAPIST		1
PHYSIOTHERAPIST		1
SENIOR STOREKEEPER		1
STOREKEEPER		1
WORKS STOREMAN		2
LADY WARDEN		2
KITCHEN SUPERVISOR		4
HOUSEKEEPER		1
TELEPHONE OPERATOR		3
AMBULANCE OFFICER		1
AMBULANCE DRIVER		3
SENIOR HOSPITAL PORTER		1
HOSPITAL PORTERS		5
SENIOR WORKS FOREMAN		1
HANDYMAN		1
PAINTER		1
BRUSH HAND		3
BOILER ATTENDANT		2
CRAFTWORKER		1
SEAMSTRESS		4
HOSPITAL COOK		8
HOUSEMAIDS		36
LABOURERS		14
MALE ORDERLY		64
VAN DRIVER		1
SENIOR CLERK		1
CLERKS		2
SENIOR WOMAN ASSISTANT		1
WOMAN ASSISTANT		1
ENGINEERING STAFF ARTISAN		1
CARPENTER		1

COMMUNITY HEALTH CARE

NURSING PERSONNEL

D E BILLES,	Certs. S A Nursing Council (Gen & Midwif)., R S H., Health Visitor and School Nurse	Chief Public Health Nurse
A P GEARY,	Certs. S A Nursing Council (Gen & Midwif)., R S H., Health Visitor	Senior Public Health Nurse
D HORNE,	Certs. S A Nursing Council (Gen & Midwif)., R S H., Health Vistor	Senior Public Health Nurse
M C KOTZE,	Certs. S A Nursing Council (Gen & Midwif)., Nat. Dipl. in Public Health Nursing	Senior Public Health Nurse
M VILJOEN,	Certs. S A Nursing Council (Gen & Midwif)., R S H., Health Visitor and School Nurse	Senior Public Health Nurse
D ENGEL,	Certs. S A Nursing Council (Gen & Midwif)., R S H., Health Visitor and School Nurse	Senior Public Health Nurse
U N NONGAUZA	Certs. S A Nursing Council (Gen & Midwif)., R S H Health Visitor and School Nurse	Senior Public Health Nurse

PUBLIC HEALTH NURSES	62
CLINIC SISTERS	61
MALE NURSES	3
NURSING ASSISTANTS	6
LEARNER PUBLIC HEALTH NURSES	7

OTHER PERSONNEL		
B CROWHURST,	B A., R S H., Meat & Other Foods	Health Education Officer
M J WALKER,	Dipl. Soc Sc.	Senior Social Worker
RADIOGRAPHER		4
CLINIC ASSISTANTS		29
MOTOR VEHICLE DRIVERS		8
CARETAKER/CLEANERS		8
DOMESTICS		31
LABOURERS		4
LAUNDRESSES		2
HEALTH EDUCATION LECTURERS		2
COOKING/HANDS		6

DENTAL SERVICES

J J VAN DER LEIJ,	B D S.	Principal Dental Officer
N E POPKISS,	L D S., R C S.	Senior Dental Officer
R HOWGATE,	L D S., R C S.	Assistant Dental Officer
SENIOR DENTAL NURSE		1
DENTAL NURSES		7
CLINIC ASSISTANTS		5
SOCIAL WORKER		1
SENIOR DENTAL MECHANIC		1
DENTAL MECHANICS		4
SENIOR CLERK		1
CLERKS		2
WOMAN ASSISTANT		1
CARETAKER/CLEANER		1
LAUNDRESS		4
LABOURER		1
DOMESTIC		1
Vacant		Assistant Dental Surgeon

FAMILY PLANNING

J T LOW,	Certs. S A Nursing Council (Gen & Midwif)., Cytology	Senior Family Planning Nurse
J RUBIN,	B A (honours)	Family Planning Liaison Officer
FAMILY PLANNING NURSES		2
CLINIC SISTERS		3
NURSING ASSISTANT		1
SENIOR ADVISER, FAMILY PLANNING EDUCATION		1
ADVISER, FAMILY PLANNING EDUCATION		12

HEALTH INSPECTION

B J DANIELS,	Certs. R S H., Meat and Other Foods	Chief Health Inspector
D E C FILBY,	Certs. R S H., Meat and Other Foods	Senior Assistant Chief Health Inspector
J A MUNRO,	Certs. R S H., Meat and Other Foods	Assistant Chief Health Inspector
A H BAIN,	Certs. R S H., Meat and Other Foods	Divisional Health Inspector
K U BRAND,	Certs. R S H., Meat and Other Foods	Divisional Health Inspector
R A OCKELFORD,	Certs. R S H., Meat and Other Foods	Divisional Health Inspector
B F A SCHUMANN,	Certs. R S H., Meat and Other Foods	Divisional Health Inspector
E H T VAN ZYL,	Certs. R S H., Meat and Other Foods	Divisional Health Inspector
HEALTH INSPECTORS		43
LEARNER HEALTH INSPECTORS		8
CLERKS		2
WOMAN ASSISTANTS		2
WORKS CLERICAL ASSISTANTS		3
SENIOR STOREMAN		1
MOTOR VEHICLE DRIVER		1

CHALET ATTENDANTS	162
LABOURERS	4
WASHHOUSE CARETAKER	4
ASSISTANT WASHHOUSE CARETAKER	1

PEST CONTROL SECTION

PEST CONTROL OFFICERS	4
PEST CONTROL OPERATIVES	26

MILK CONTROL

D DIXON, B Sc., B V Sc.	Senior Veterinary Officer
DAIRY INSPECTORS	3
LABORATORY ASSISTANT	1

NURSERY SCHOOLS AND CRECHES

J M EBDEN, Cert. Nur. Sch. Teachers	Supervisor of Nursery Schools
SENIOR NURSERY SCHOOL TEACHERS	8
NURSERY SCHOOL SUPERINTENDENTS	3
NURSERY SCHOOL TEACHERS	5
NURSERY ASSISTANTS	14
CRECHE SUPERINTENDENTS	8
CHILDRENS HELP	16
COOKING HANDS	11
LAUNDRESS	8
DOMESTICS	14
CARETAKER	1
LABOURERS	7

SECTION II

NATURAL AND SOCIAL CONDITIONS

PHYSICAL GEOGRAPHY

Cape Town is situated at the northern end of the Cape Peninsula. The Peninsula lies on the west coast of the mainland of South Africa, extending from north to south a distance of about 50 Km and attaining a maximum width of about 16 Km. Its average width east and west may be estimated at 8 Km. The northern half of its eastern side is connected with the mainland by a wide low-lying sandy isthmus, known as the Cape Flats, which separates Table Bay to the north-west from False Bay to the south-east. The narrowest part of the isthmus measures about 20 Km from sea to sea.

The backbone of the Peninsula is a mountain range which extends from Table Mountain (1082m) at its north end to Cape Point at the south. The land slopes from the mountains to the sea or, where the isthmus joins the Peninsula, to the Cape Flats. While much of the Peninsula area lies at heights of over 300m, most of the isthmus does not reach 30m, and a rise of sea level would convert the Peninsula into two islands nearly equal in area.

From the bottom of the slope below the face of Table Mountain there extends down to Table Bay a bed of alluvial deposits, on which a good deal of old Cape Town is built. At the shore of the Bay there is a considerable area of land that has been reclaimed from the sea as the result of the construction of the new harbour.

The City of Cape Town consists of a central portion which, before the City extension of 1913, constituted the whole Municipality and is sometimes known as Cape Town proper or central Cape Town (Wards 2–6), and a chain of suburbs on either hand. The central portion lies in the amphitheatre which, extending down to Table Bay towards the north-east, is backed on the other sides by the precipitous face of Table Mountain and its outlying masses, Devil's Peak on the east and Lion's Head and Signal Hill on the west. It therefore lies between the mountain and the sea, and, unlike the centre of most cities, is not surrounded by its suburbs.

The suburbs extend beyond this amphitheatre on either hand. To the west, marine suburbs known as Green Point, Sea Point, Camps Bay and Bakoven (Wards 1, 2 and 3) lie along the Atlantic sea board for a distance of about 10 Km curving with the coast in a southerly direction. They are on the seaward slopes of Signal Hill and Lion's Head.

To the east the 'Southern Suburbs' (Wards 7 to 17) extend around Devil's Peak and are stretched for about 24 Km along the road and suburban railway line which after rounding Devil's Peak pass along the eastern side of Table Mountain in a southerly direction to the shore of False Bay.

Woodstock and Salt River (Ward 8), next to Cape Town proper, slope down to Table Bay and at the other end Muizenberg, St. James and Kalk Bay (Ward 17) lie on the False Bay coast. The string of suburbs between known successively as Observatory, Mowbray, Rosebank, Rondebosch, Newlands, Claremont, Kenilworth, Wynberg, Plumstead, Diep River, Heathfield, Retreat and Lakeside, lie on the eastern slopes of the Mountain range, and, to a greater extent, on the Cape Flats below this range. (Map 1).

The Municipality extends over the Cape Flats to a varying depth of up to 8 Km and is today being extensively developed for industrial and residential purposes. Some of the largest Coloured and Black residential townships have within recent years been laid out in these areas and are served by the Cape Flats railway and the Nyanga link which form loops lying in a more easterly direction than the main suburban line.

There is an extension of the Municipality beyond Salt River in a north-easterly direction on the Flats bordering Table Bay. This (Ward 9) includes the suburbs of Maitland, Brooklyn, Rugby, Kensington and Thornton which, together with other townships lying outside the municipal area of the city and following the main road to the north are known as the 'Northern Suburbs'.

AREA

The incorporation of an area of 1824, 1325 hectares (being Mitchells Plain) increased the Municipal area to

2 9970,2893 hectares as at 1976–12–31. The length of the main road passing through the municipality from the boundary at Bakoven to that at Clovelly is about 40 kilometres.

CLIMATE

Cape Town is situated in Lat. 33°55'S., Long. 18°25'E,. Its climate is largely determined by the fact that during the summer season the prevailing winds are south-easterly and in the winter north-westerly; and that the western shore of the Cape Peninsula is washed by a cold current from the Antarctic.

There is an average of nearly three thousand hours of bright sunshine per year, and the temperature is equable. The rainy season is in the winter, but occasional showers also occur in the summer months of December, January, February and March. Those areas of the municipality situated on the two seaboards are much frequented by holiday-makers from other parts of the country. To the attractions of the climate are added the great natural beauties of the Peninsula and its hinterland.

From the point of view of public health Cape Town belongs to the temperate zone, and tropical diseases , except for imported cases, are entirely absent. The state of health and the mortality statistics of the White portion of the population are much the same as would be expected in a socio-economically advanced European city.

The officer-in-charge, Weather Office, D.F. Malan Airport,has kindly supplied the information that during 1976 a total of 565,4 mm of rainfall was recorded, the rain falling over 130 days. The highest annual rainfall in the two decades since 1957 was 716,4 mm in 1962. The average maximum temperature was 21.4°C with the maximum recorded temperature being 35,2°C on 1976–02–29. The average minimum temperature being 12°C with the minimum temperature recorded being 0,2°C on 1976–06–21. Meteorological data for the past decade is given in Table II.I

It should be noted that the D.F. Malan Airport lies outside the Municipal boundaries and that different areas of Cape Town experience widely differing weather patterns during the year, and even on the same day, because of the topography.

SOCIAL AND ECONOMIC CONDITIONS

There was a general slowing down of economic activity during the year under review, with a concomitant rise in unemployment. A high rate of inflation and a general stagnation of salaries and wages led to widespread difficulties in maintaining previously attained standards of living.

There was a period of civil unrest during the year which affected attendance at many clinics and which coincided with a temporary drop in the Notification of Black births, possibly because expectant mothers who would normally have travelled to Cape Town for their confinements did not feel it appropriate to do so.

30 per cent of the total population of the Municipality of Cape Town (including the Bantu Affairs Administration Board areas of Langa and Guguletu) of 842620 consists of Whites.

57 per cent of the total population consists of Coloureds who are largely the descendants of the slaves of earlier days, whose emancipation was completed in 1835. Their ancestors of the eighteenth century and earlier were mainly Europeans, Hottentots, blacks from Mozambique, Madagascar and other parts of Africa, and East Indians from the Dutch East Indies. In more recent years they have received additions from White, Black and other stocks.

There is one section of the Coloureds, Moslem in religion, known as 'Malays' who are more immediately descended from the Dutch East Indies. Though they possess a larger infusion of this strain, they are much mixed with other elements present in the Coloureds.

The social and economic conditions of the Coloureds are on the whole unsatisfactory although recent improvements have become apparent. A section of them are skilled tradesmen and earn good wages but the majority are unskilled labourers and many of the men earn less than R40 a week when in full employment. The position is aggravated by the large size of their families.

The family income may be augmented where possible by earnings brought in by the wife and children. The

measures taken for the prevention and relief of distress are inadequate, and there is no compulsory insurance against sickness. There is much malnutrition, and housing accommodation apart from municipal schemes is expensive and poor. The social and cultural level is low but is showing signs of steady improvement. The illegitimacy rate is high and venereal disease is rife. The social contrast between Whites and Coloureds can be expressed by the statement that whereas in the Whites it is only a small minority that belong to the depressed classes, in the Coloureds it is the majority. The same contrast is seen in housing conditions; it is a small minority of Whites who live in overcrowded conditions, but a majority of the Coloureds.

The Black or Bantu group constitute only 12^{0}/o of the Cape Town population. They live in the Bantu Affairs Administration Board areas of Langa and Guguletu, or if in domestic service, in their employers' homes. Many of the Blacks are males from the Bantu homelands who still retain their link with the territories and usually return there eventually; but there is an increasing population of detribalised Bantu who are permanently resident in Cape Town and live here with their families. Their social and economic conditions are on the whole worse than those of Coloured people.

The Asians total 11050 in number. They are nearly all traders, and are better off than the Coloureds. Some of them are making good progress in business and are well-to-do.

There are parts of the city where the inhabitants are mainly Coloured, Black or Asian and other parts that are exclusively occupied by Whites and their non-White servants. The various sections of the community, however are to a great extent inter-mingled, and there is not yet complete segregation of the races. The State Department of Community Development has commenced to unscramble the present hotch-potch of White and non-White residential areas. This activity is placing additional strain on the local authority's attempt to reduce overcrowding and clear the many slums in the city area, as the requirement by this State Department for newly constructed municipal economic and sub-economic homes, amounts to as much as 50 per cent. The geographical distribution of White and Coloured is very much the same as that of well-to-do and poor in a European town. In the planning of housing under the Housing Act the estates for Whites are separate from those for non-Whites and this will contribute to progressive and complete residential separation.

Striking contrasts are presented by the vital statistics of the different races, which will be found in the next section of this report.

MUNICIPAL WARDS

The City is divided into 17 wards, varying in area from the smallest (Ward 2—Sea Point) to the largest (Ward 17).

The following is a guide to the more important areas which may be identified on Map 1.

Ward	1	Camps Bay
Ward	2	Sea Point
Ward	3	Three Anchor Bay, Green Point and Mouille Point
Ward	4	Tamboerskloof
Ward	5	Oranjezicht and Vredehoek
Ward	6	Central Area
Ward	7	Harbour Area
Ward	8	Lower Woodstock and part of Salt River
Ward	9	Maitland, Brooklyn, Kensington and Thornton
Ward	10	Observatory and Mowbray
Ward	11	Rondebosch
Ward	12	Bergvliet and Meadowridge
Ward	13	Athlone, Langa, Guguletu, Crawford and Lansdowne
Ward	14	Newlands and part of Claremont
Ward	15	Kenilworth and Wynberg
Ward	16	Plumstead, Southfield, Heathfield and part of Ottery
Ward	17	Heathfield to Clovelly

MAP 1: *CAPE TOWN SUBURBS*

SECTION III

VITAL STATISTICS

(Summary data in Tables I.I and III.II).

DEMOGRAPHIC DATA

TOTAL POPULATION.

Calculation. The Population estimates for 1976 used in this report are calculated as on 1976–06–30, using annual growth rates of 1,486^{0}/o for Whites, 3,734^{0}/o for Coloureds and 2,727^{0}/o for Asians (These rates being calculated from the growth in population between the 1960 and 1970 Censuses).

The Black Population estimate has been obtained from the Bantu Affairs Administration Board whose figures are more reliable than those of the Census (although there is little doubt that even these figures are too low).

The Population for 1976 (Table I.I) totalled 842 620 which was an increase of 74,1^{0}/o over the 1957 population (Table III.I). Of this twenty year growth in population 1,1^{0}/o was due to the increase in Asian, 10,5^{0}/o to that in Black, 17,3^{0}/o to that in White and 71,1^{0}/o to that in Coloured numbers (Fig. 3.1).

The percentage change within each race group from 1957 to 1976 was an increase of, for Whites 32,5^{0}/o; Asians 65,3^{0}/o; Blacks 59,6^{0}/o and Coloureds 114,5^{0}/o.

Population figures by race and sex for 1975 and 1976 are contained in Table III.III and reveal the interesting fact that male : female ratios differ markedly between the race groups, being 100 : 110 for Whites; 100 : 113 for Coloureds; 100 : 92 for Asians and 100 : 54 for Blacks.

The White and Coloured preponderance of females is probably due to the greater susceptibility of males to the major killing diseases of our times; the preponderance of Black males is ascribed to Government policy on Black migration but the Asian figures are an enigma. The 2205 Asian births notified 1967 to 1976 showed a male : female ratio of 100 : 88 which indicates a possible field of study.

POPULATION PYRAMIDS.

Age – Sex Population Pyramids for the different race groups have not as yet been compiled specifically for the Municipal area. For the whole of the 01 economic region, (which includes Cape Town, Bellville, Wynberg, Simonstown Magisterial districts) the picture presented in Figure 3.2 has been compiled from data provided by the Director, Technical Management Services, City Engineer's Department.

On this figure females account for 51^{0}/of the White and 53,2^{0}/o of the Coloured population.

Preliminary analysis of various well-defined sub-communities in Cape Town indicates that there is a tremendous variety of population pyramidal shapes in different parts of Cape Town, even amongst members of the same race group. Examples are shown for various Health districts, and as an estimate for the City, in Figure 3.3 (age pyramids, without sex differentiation, as reflected by the 1970 census).

Whites. The 1970 hemi-pyramid had an almost upright rectangular form with bulges at the 20 – 24 years and 65 years plus age group. The younger adult bulge is in part due to the concentration of pupils and students in the Claremont Health District but is also obviously due to the attractions the Central and Atlantic areas have for young adults (unlike the Maitland, Lansdowne and Wynberg areas).

The greatest proportion of older persons (65 years or more) in a Health district is found in the Atlantic area, followed by Claremont, Central and Salt River areas.

Coloureds. The 1970 hemi-pyramid had a hemi-triangular, staircase shape. Those areas with the newest Housing estates showed the broadest based pyramids (Manenberg, Lavender Hill, Parkwood and Heideveld). Somewhat better established areas showed a contraction in the 0 – 4 year age group (Silvertown, Kensington,

Figure 3.1 *POPULATION GROWTH OF THE CITY OF CAPE TOWN: 1957 to 1976*

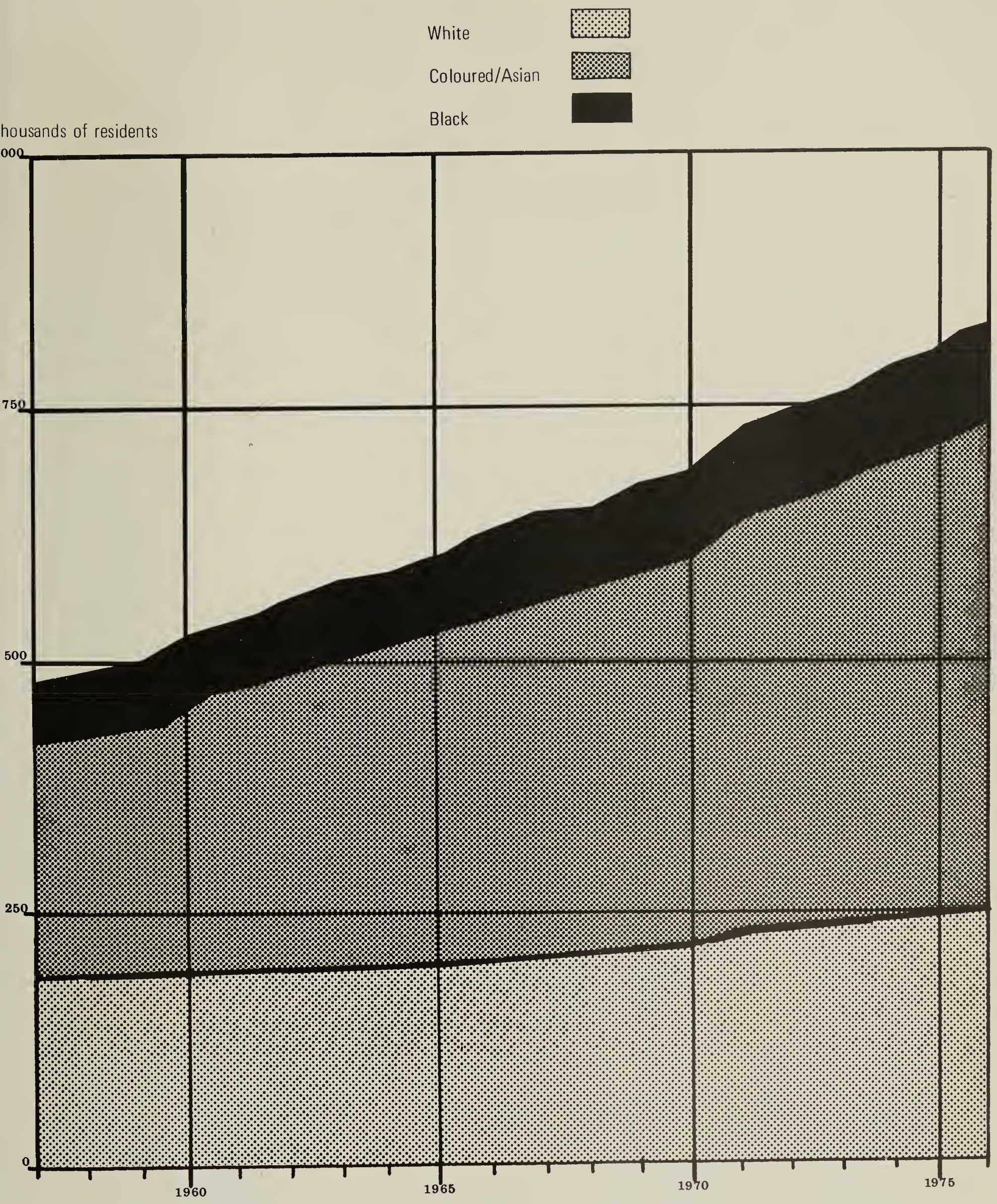
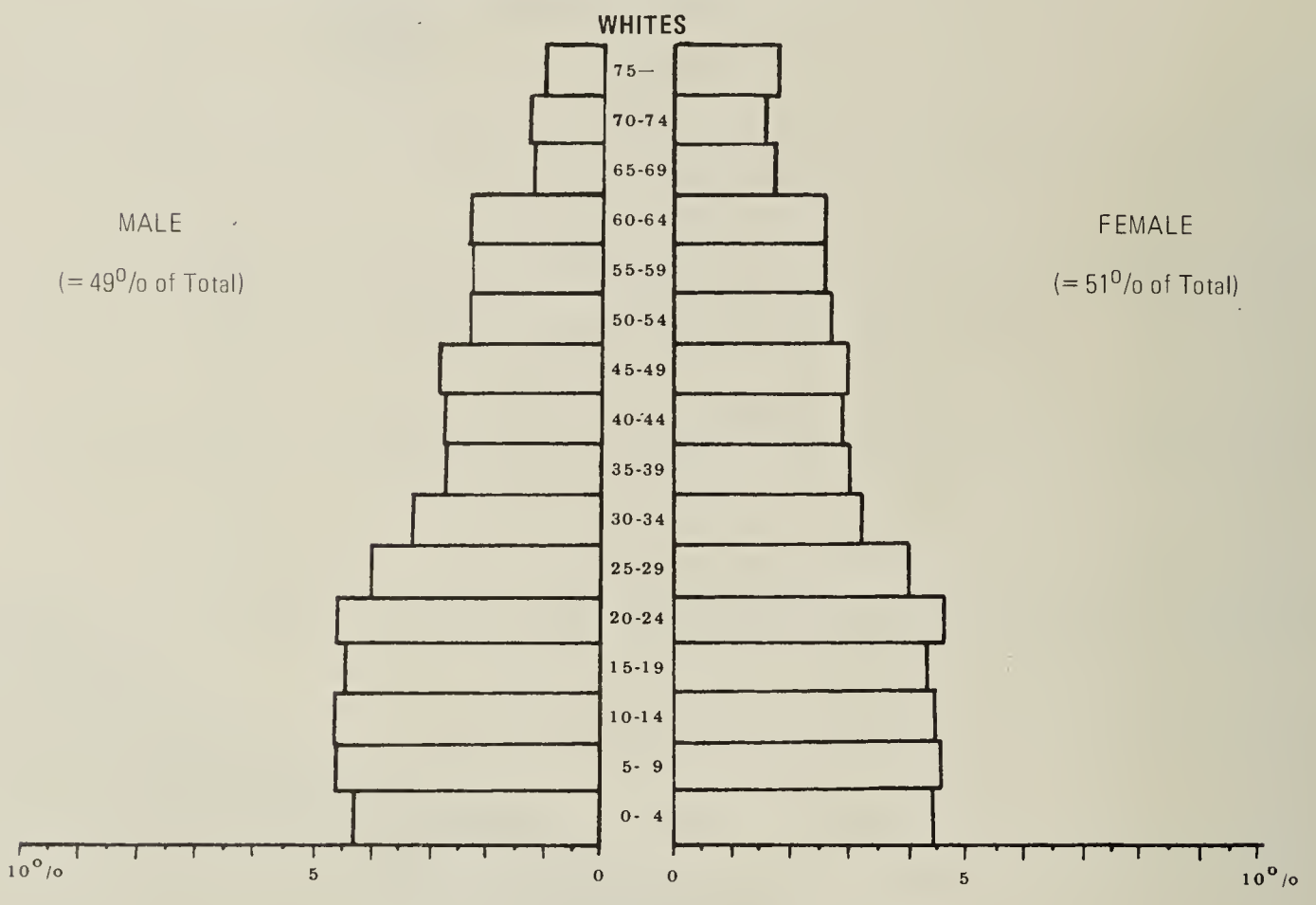
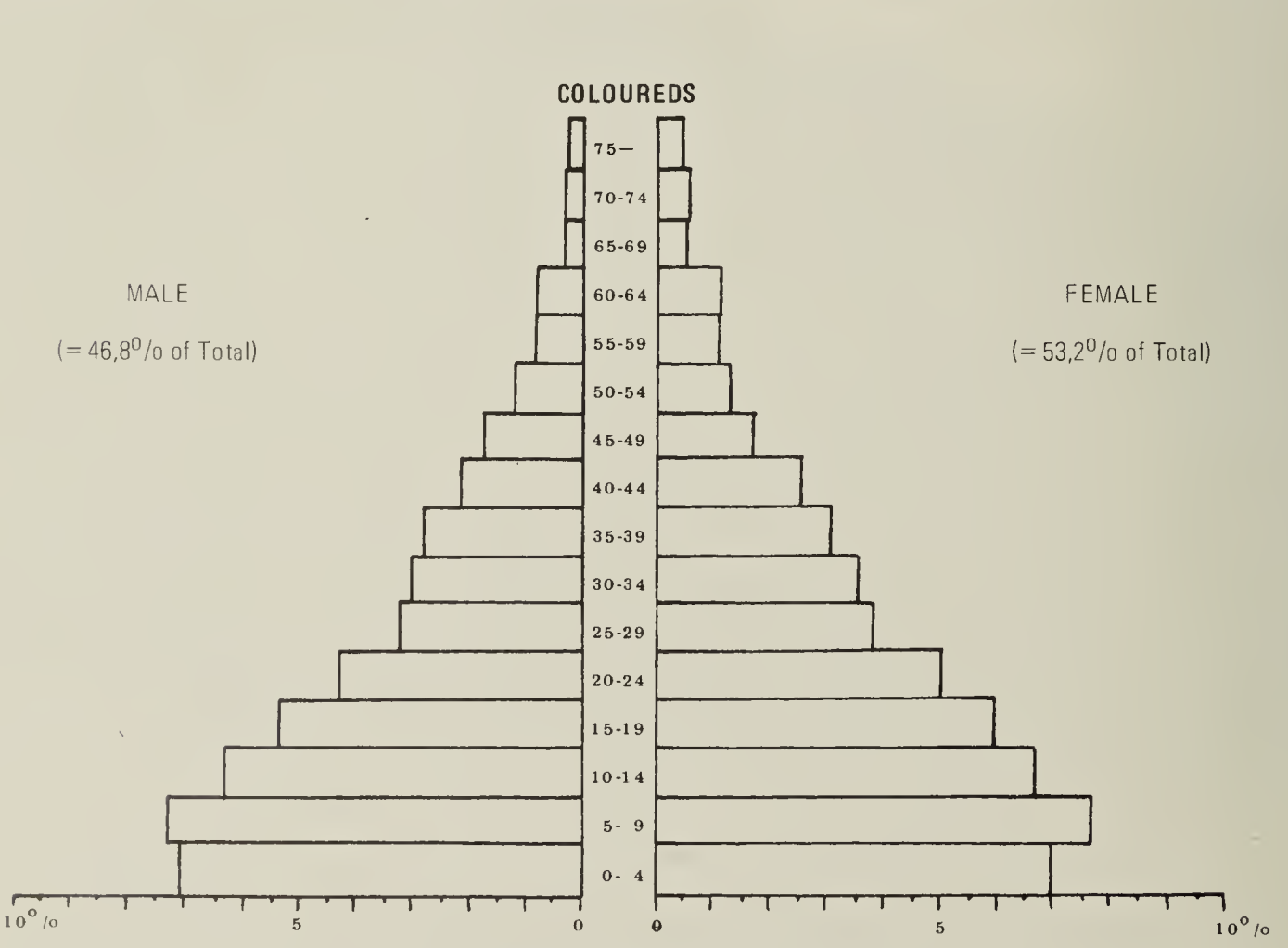


Figure 3.2: *POPULATION PYRAMIOS BY SEX AND FIVE YEAR AGE-GROUP INTERVALS FOR WHITES AND COLOUREDS IN THE 01 ECONOMIC REGION (MAGISTERIAL OISTRICTS OF CAPE TOWN, WYNBERG, SIMONSTOWN AND BELLVILLE). **

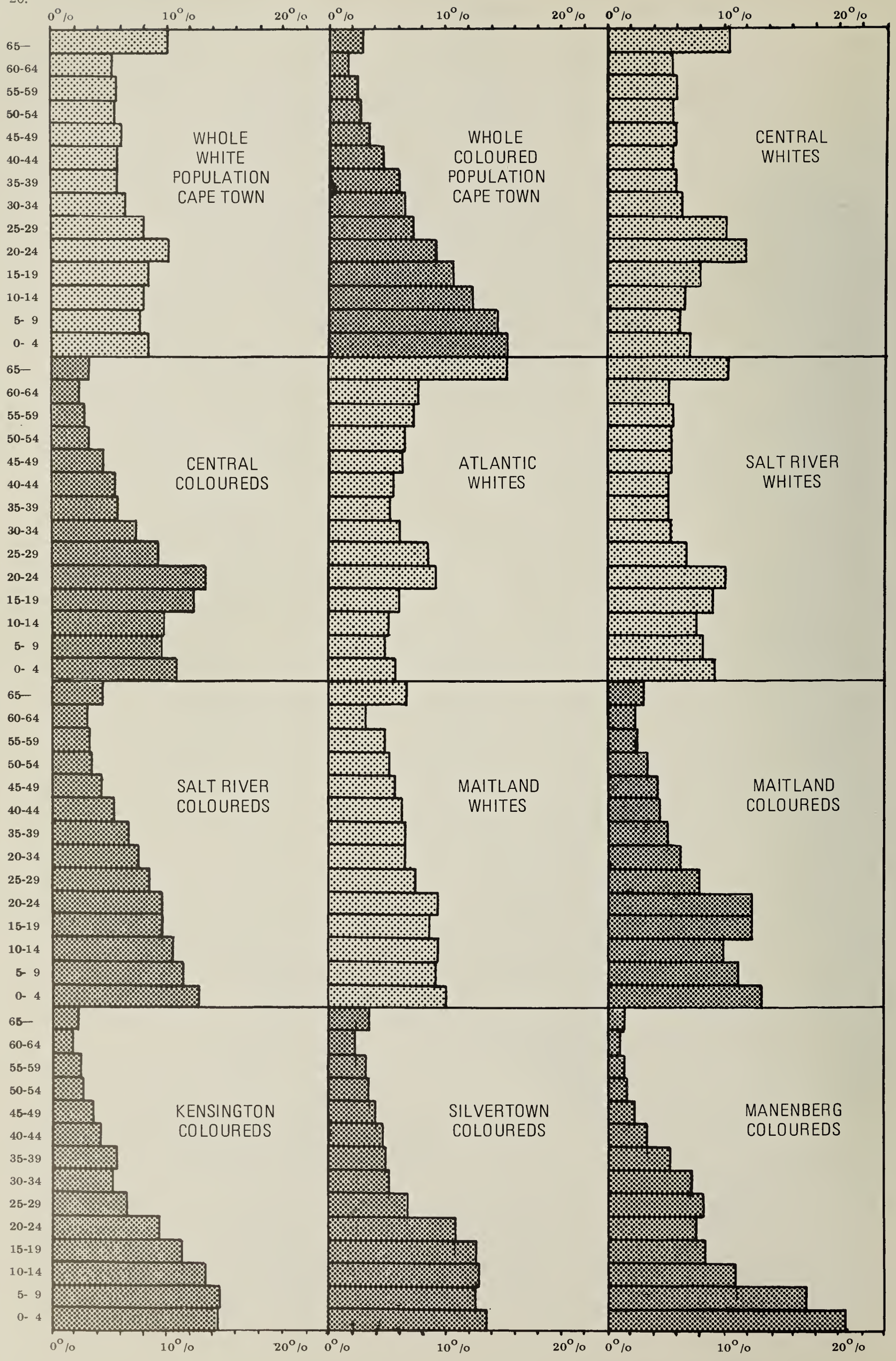




* Source: Technical Management Services of the City Engineers Department, City of Cape Town.
Data from 1970 Census.

MAP 2: *HEALTH DISTRICT BOUNDARIES FOR THE COLLECTION OF BASELINE DEMOGRAPHIC DATA.*

N1	District Six	E1	Silvertown	S1	Wynberg
N2	Central	E2	Manenberg	S2	Retreat
N3	Atlantic	E3	Hanover Park	S3	Lavender Hill
N4	Salt River	E4	Newfields	S4	Parkwood
N5	Maitland	E5	Heideveld	S5	Lansdowne
N6	Langa	E6	Bonteheuwel	S6	Claremont
N7	Kensington	E7	Netreg	S7	Guguletu
		E8	Mitchells Plain		


0°/o
10°/o
20°/o
65—
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5- 9
0- 4
WHOLE WHITE POPULATION CAPE TOWN
WHOLE COLOURED POPULATION CAPE TOWN
CENTRAL WHITES
CENTRAL COLOUREDS
ATLANTIC WHITES
SALT RIVER WHITES
SALT RIVER COLOUREDS
MAITLAND WHITES
MAITLAND COLOUREDS
KENSINGTON COLOUREDS
SILVERTOWN COLOUREDS
MANENBERG COLOUREDS

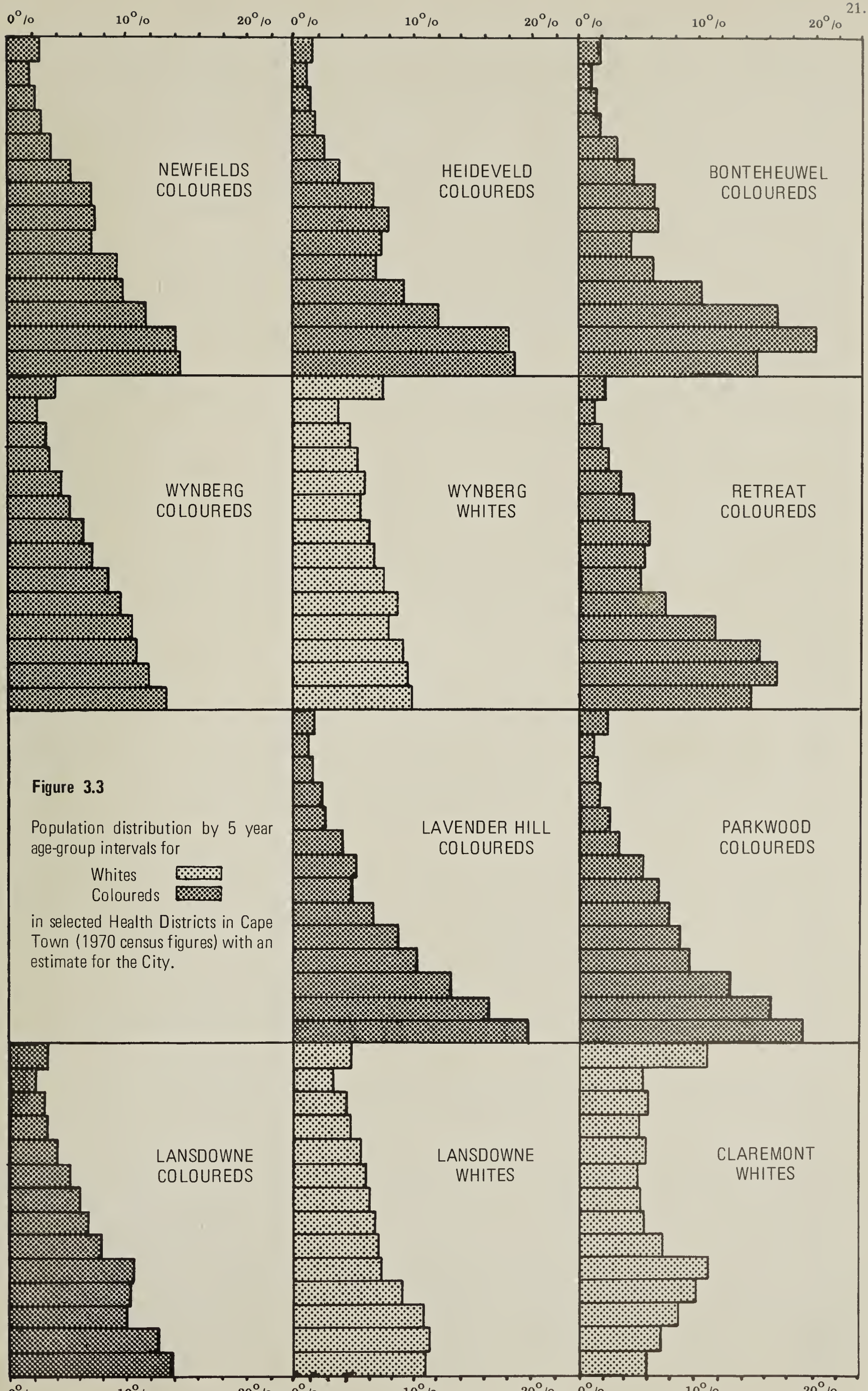


Figure 3.3

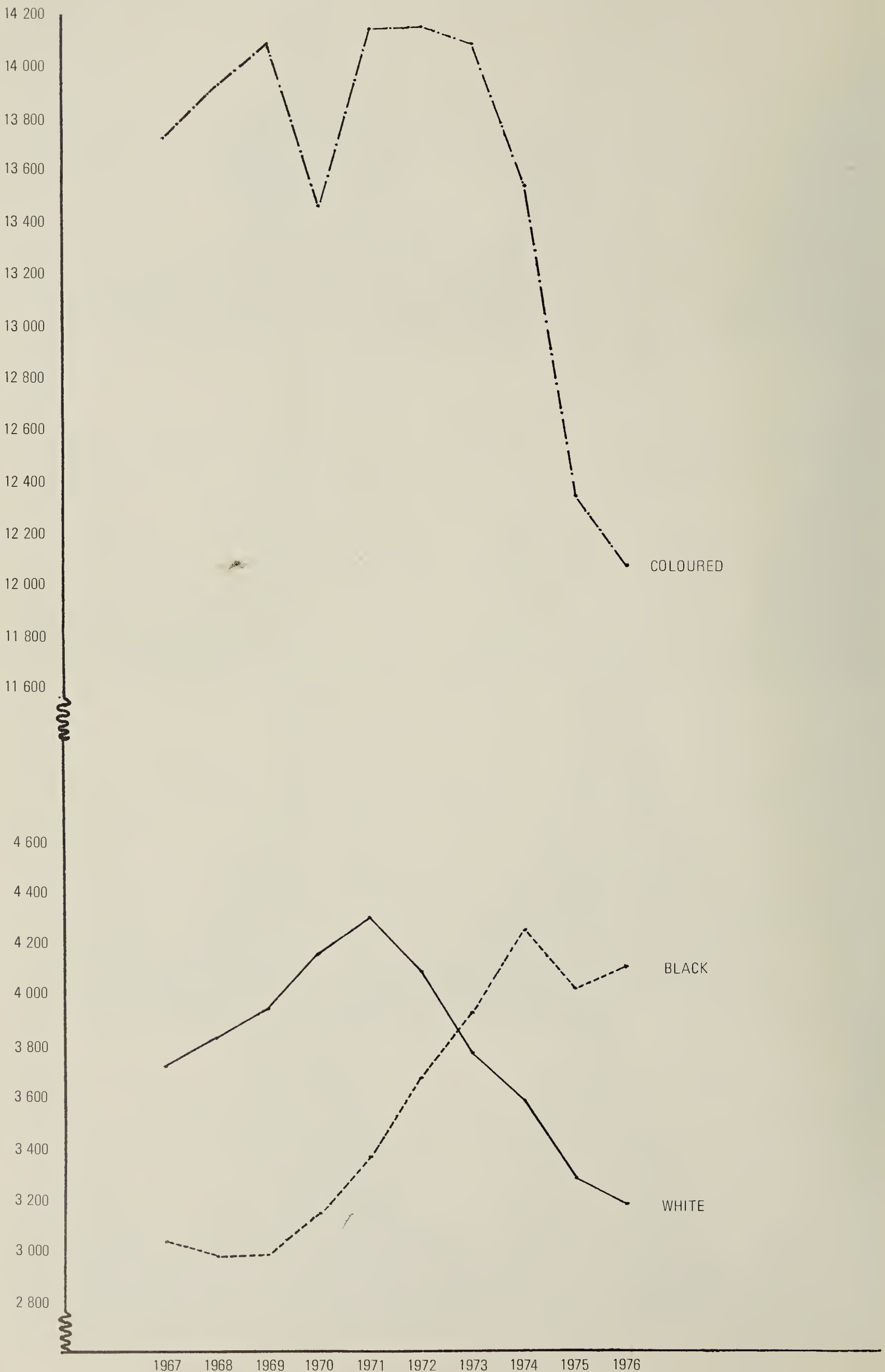
Population distribution by 5 year age-group intervals for

Whites

Coloureds

in selected Health Districts in Cape Town (1970 census figures) with an estimate for the City.

Figure 3.4: *THE NUMBERS OF WHITE, COLOURED AND BLACK LIVE BIRTHS TO CAPE TOWN RESIDENTS NOTIFIED ANNUALLY FROM 1967 – 1976.*



Newfields, Retreat) while Bonteheuwel showed this and a lack of 15 to 34 year olds. In the multiracial districts of Wynberg, Lansdowne and Maitland the Coloured and White hemi-pyramids showed a remarkable degree of similarity although this was less so with the Central and Salt River districts.

REORGANISATION OF DATA COLLECTION

In tandem with the establishment of a Comprehensive Health Service (see page 41) the basis for a new system of data collection has been blueprinted.

In essence this involves the geographic division of the Municipal area into Health Districts (HD).

In defining the boundaries of these HD certain objectives were set, namely to allow for the establishment of a data base with reasonable ease, to ensure that this data base could be relied upon to yield accurate and significant data, to take into account the technical resources (chiefly clinic buildings) extant, to take due cognisance of the preferences of the population domiciled therein for particular points of health care delivery, to base HD on community Health Centres easily accessible to all the inhabitants, to allow for maximum utilisation of all groups of staff and to offer them maximum opportunity and to take natural and man-made boundaries into account (ultimately basing boundaries on those of census enumerator subdistricts of the 1970 census).

Some 22 Health Districts have been delineated (see Map 2.) and some preliminary demographic data in relation to some of them is presented in Figure 3.3 and is tabulated in Table III.IV.

It is intended to proceed with revision of all data collection so that pertinent data pertaining to their health status can be related to defined communities; so that the work of the health services can be evaluated and so that the effect of innovative measures can be accurately assessed.

BIRTHS

Notification of Births

Warning has been received that the Government Regulation re the Early Notification of Births made under Section 133 (1) of the Public Health Act, Act 36 of 1919 is destined to be withdrawn. The Secretary for Health has been informed that the early notification of births is considered to be **vitally important** for the proper provision of promotive and preventive infant welfare services and for the collection of data essential to the preparation of meaningful Birth, Still Brith, Perinatal, Neonatal, Post-neonatal and Infant Mortality rates.

Recording of Registered Births registered in terms of the Births, Marriages and Deaths Act, Act 81 of 1963 was discontinued some years ago by this Department because of their patent inadequacy. It is reiterated that all information relating to Notified Births is available to the Registrar of Births and Deaths and that there can be no misapprehension about the misgiving with which this announcement has been met.

Notified Live Births and Birth Rates

There were 102 fewer (−3,1%) White, 264 fewer (−2,14%) Coloured, 84 more (+2,08%) Black and 24 more (+10%) Asian live births to mothers resident in Cape Town during 1976 than in 1975.

The trend in terms of actual numbers of such births is shown in Figure 3.4 (page 22) which covers the years 1967 – 1976 (but which for clarity excludes Asian live births; these account for only 1.3% of all live births).

Table III.V details live births by race and sex for 1975 and 1976 and indicates that the Birth rates for each race group in those two years altered but slightly (slight decreases for White, Black and Coloured and slight increases for Asian birth rates).

N.B.: birth rate (BR) = $\frac{\text{Number of live births during the year}}{\text{Midyear Population}} \times 1\,000$

Trends in numbers of live births and birth rates by race 1972 – 1976 are contained in Table III.VI which

shows a steady drop in both parameters for the White Group which must lead inevitably, and fairly soon, to zero population growth. While there is a steady fall in numbers and birth rates for the Coloured group, this is a gentle fall. The Black and Asian birth rates do not show a clear five year trend in either direction.

Still Births (SB) and Still Birth Rates (SBR)

There was a slight increase in the SBR for Whites (from 6,6 to 8,1) and Coloureds (from 15,6 to 16,5); a slight decrease for Blacks (from 23,5 to 21,6) and a large decrease for Asians (from 12,3 to 7,5) in 1976 compared with 1975 – See Table III.VII.

In addition to the 322 SB to municipal residents there were 67 such births to non-resident mothers notified to this Department in 1976 (compared to 317 and 66 in 1975).

N.B.: $$\text{SBR} = \frac{\text{Number of Still Births in the year}}{\text{Total live and still births in that year}} \times 1\,000$$

The association of illegitimacy and SB is discussed below and can be gauged from Table III.XIV.

Multiple Births

There were 221 pairs of twins and three sets of triplets (Black; all sets of mixed sexes) notified in 1976 (continuing an established trend). The twins are classified according to race and as to whether of the same or mixed sexes in Table III.VIII.

Place of Occurrence of Births/Birth attendants

The trend for deliveries to take place in institutions continued in 1976 when 77% of live and still births to municipal residents were so classified (see Table III.IX). Of all live or still births notified irrespective of the residential status of the mother, 80,9% of deliveries took place in institutions (see Table III.X).

Legitimacy

The percentage of Live Births that were illegitimate was slightly higher for Whites, Coloured and Blacks but lower for Asians in 1976 than in the previous year (see Table III.XI).

The high percentage (72%) of births to teenage mothers that were illegitimate continues the established pattern in this regard and these births are classified by age and race of the mother in Table III.XII.

The trend towards an ever higher percentage of illegitimate births over the past quarter century is shown in Table III.XIII with the 1976 figure being 38,2% of total live births.

To place local illegitimacy in perspective it is interesting to compare the percentages of White and Black Live births that were illegitimate in Cape Town in 1976 (10,5% and 58,2% respectively) with figures for Whites and Blacks in Washington, United States of America in 1975 (12,9% and 57% respectively)*.

* US National Centre for Health, reported in the Cape Times 1976–11–12.

DEATHS

"Uncorrected Deaths" – deaths registered during the year as having occurred in the Municipality of Cape Town, **including** inward transfers of deaths of municipal residents which took place outside the municipal area.

"Corrected Deaths" – deaths as above but minus the outward transfer of non-resident deaths which took place in the municipality of Cape Town.

"Crude death Rate" = $\frac{\text{Number of deaths during the year}}{\text{Mid-year Population}}$ x 1 000

"Infant mortality Rate" (I.M.R.) = $\frac{\text{Number of deaths of infants aged less than 1 year in the year}}{\text{Total live births in that year}}$ x 1 000

"Perinatal mortality Rate" (P.M.R.) = $\frac{\text{Number of still births and deaths of infants aged less than one week during the year}}{\text{Total live and still births during that year}}$ x 1 000

"Early Neonatal Mortality Rate" = $\frac{\text{Number of deaths of neonates aged under 7 days during the year}}{\text{Total live births in that year}}$ x 1 000

"Late Neonatal Mortality Rate" = $\frac{\text{Number of deaths of neonates aged 7 – 28 days during the year}}{\text{Total live births in that year}}$ x 1 000

"Neonatal Mortality Rate" = $\frac{\text{Number of deaths aged 0 – 28 days during the year}}{\text{Total live births in that year}}$ x 1 000

"Post-neonatal Mortality Rate" (P.N.M.R.) = $\frac{\text{Number of deaths of infants aged over 28 days but less than one year during the year}}{\text{Total live births in that year}}$ x 1 000

Deaths registered in 1976 may have taken place in 1975, and some deaths taking place in 1976 were not registered in that year so are not included in the total.

Information pertaining to Deaths is extracted from the records of, and by courtesy of, the Minister of the Interior.

The validity of the data as to cause of death can be questioned on a number of grounds e.g. –

(a) most cases are not subjected to post-mortem and the diagnosis made is thus a clinical one;

(b) even where the medical practitioner is confident of the clinical diagnosis the certificate may be difficult to read or interpret, it may give unclassifiable causes of death or it may give more than one cause of death with no indication of which one the doctor considered the actual cause of death;

(c) even where the actual cause of death is known and stated it is often arguable whether or not an underlying or precipitating cause of that condition should be regarded as the cause of death;

(d) the data collated and analysed here is not original but consists of transcripts made by clerical staff of this Department;

(e) the grouping of certain International Classification of Diseases Code numbers in classifying causes of Deaths follows a traditional and arbitrary pattern – it is intended to review this in future reports;

Unless production of these annual reports was delayed by at least six months it is not expected that all data relating to deaths occurring in a particular year will have filtered through to this Department, hence it is not possible to classify deaths by the month in which they occurred but only by the month in which the registration became known to this Department (it is hoped that retrospective analyses of the actual time of death of several thousand persons may be possible and should provide the first reliable indication of seasonal trends published for Cape Town).

The data relating to occupation at time of death is of limited value as the nature of work is not specified on the certificate and indeed in the case of Blacks there is no occupational data available.

Age – sex – cause – specific data is not presented owing to the lack of current demographic data, once again it is a future goal of this Department to refine crude data to such levels.

GENERAL MORTALITY

Number of Deaths and Crude Death Rate

There was a general increase in the crude death rate for each race group compared with the previous year (see Table III.XV) but no clear trend emerges over the past five years (see Table III.XVI).

There were no particular causes identified with the increase in Whites but in Coloureds the increases in the number of deaths from senility, ill-defined causes and pneumonia were prominent.

The large number (186) of deaths in the Black/Coloured/Asian combined group aged less than one year or in the middle-age group which were classified as ill-defined or unknown, is unsatisfactory.

Crude death rates for the different race group cannot be compared and contrasted to yield meaningful inferences because of the great differences in the age structures of the different population groups. A population such as the White group in Cape Town has proportionately far more middle-aged and older people (who can logically be expected to die) than children and young people, but the latter predominate in the Coloured group. (see page 32 Standardised Death Rates).

Deaths by age of death

The age of death is Tabulated in Table III.XVII but age specific death rates cannot be calculated without the denominator (population in each age group), which is not yet available.

The percentage of all deaths occurring at age 55 years or more is a health indicator because it rises as more babies survive to such ages. Figure 3.5 details the percentage of all deaths occurring at age 55 years or more for the different race group over the past ten years and in general there is a satisfactory rising trend in this regard.

However the percentage of Blacks dying at or over 55 years remains lower than that for Coloureds which in turn is lower than that for Whites.

There was little change in 1976 compared with 1975 except that the percentage of Black females dying at age 55 years or more fell slightly.

Mortality in the very young is discussed in greater detail on page 33.

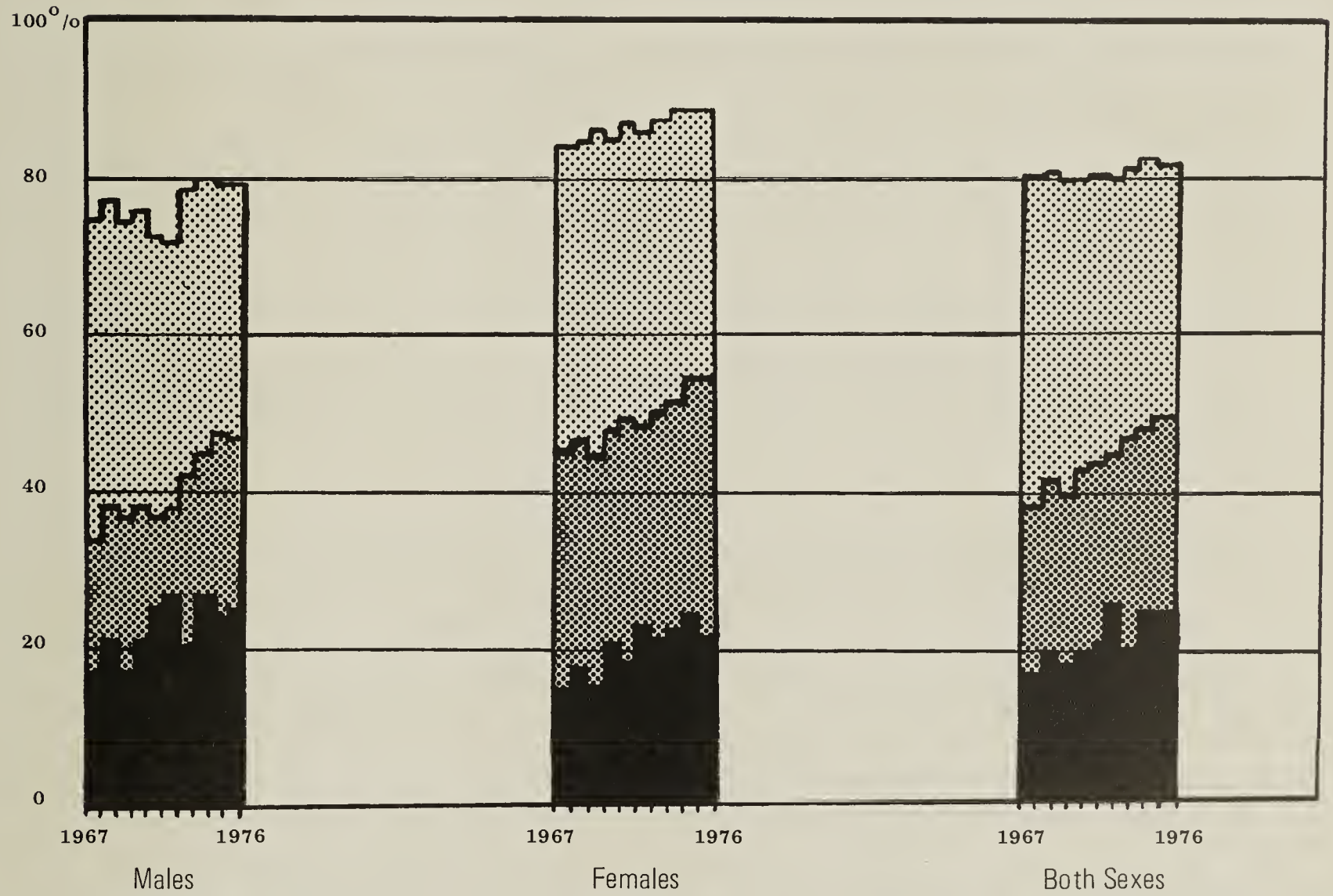
Deaths by occupation just before the event

Data in this regard is presented in Table III.XVIII but is of little value because the precise nature of the work done by the deceased is unknown, because data is often incomplete and probably inaccurate and because no information is available on the occupations of deceased Blacks.

In the table mentioned above, Black deaths have been arbitrarily classified as "Labourer" if the deceased was male and aged 15–64 years, or "Housewife" if female and aged 15–59 years; and as "Pensioner" if older.

This classification is however being retained in the Report in order that it may be refined and built upon in

Figure 3.5 *PERCENTAGE OF ALL DEATHS OCCURRING IN PERSONS AGED 55 YEARS OR MORE 1967 to 1976*



the future.

Deaths by season

Tables III.XIX and III.XXV reflect the months in which this Department became aware of the deaths shown. No inferences whatsoever can be drawn as to seasonal fluctuations as the time of death is not shown on this table (but merely receipt of the information). Again, it is intended to refine this information in the future.

Principal Causes of Death

Causes of death have been coded according to the 8th Edition of the International Classification of Diseases.

The principal 'causes' of mortality (groups of causes) in Whites and in the combined Black – Coloured – Asian group are detailed in Table III.XX and are illustrated in Figures 3.6, 3.7 and 3.8.

(**N.B.** The Table does not include "ill defined causes", which reached sixth in magnitude for both the White group and for the Black – Coloured – Asian combined group).

Kwashiorkor is no longer notifiable so that precise estimations of the incidence or prevalence of this condition cannot be made. There were, in 1974; 1975 and 1976 respectively; 17 (10 Black and 7 Coloured); 10 (8 Black and 2 Coloured) and 10 (9 Black and 1 Coloured) deaths due to Kwashiorkor.

Deaths from 'cancer' (malignant neoplasms, including those of lymphatic and haemopoeitic tissue, according to the 8th Edition I C D) totalled 958 (410 Whites, 403 Coloureds, 3 Asian and 142 Black) in 1976. These are detailed for Whites and all other races combined in Table III.XXI.

Neoplasms of the lungs and trachea are detailed in Tables III.XXII and III.XXIII. Compared with the figures of thirty years ago it is noteworthy that death rates due to pulmonary neoplasms per 100 000 of the population have increased two-fold for White males; nearly six-fold for White females; over seven-fold for Coloured/Black and Asian males; and by over four-fold for Coloured/Black and Asian females. A considerable percentage of these increases however can probably be ascribed to improved diagnostic methods.

Over the past five years an average of 16^{0}/o of pulmonary cancer deaths in Whites occurred in persons aged less than 55 years and 84^{0}/o in persons aged 55 years or more. The comparable figures for the combined Coloured/Black/Asian group were 38^{0}/o under 55 years and 62^{0}/o 55 years or more.

Diabetes mellitus displaced diseases of the nervous system as a cause of death in Whites (Table III.XX) in 1976 compared with 1975 but more attention was paid to this disease where multiple diagnoses were made than had possibly been the case in the past.

In the combined Black – Coloured – Asian group, the causes listed in Table III.XX remained the same as in 1975 but Bronchitis/pneumonia moved up to 2nd place and senility up to seventh place.

Certain causes of death are classified more precisely by race in Table III.XXIV and the ratios between infectious and degenerative diseases can be seen to be quite different in the White group to the Black and Coloured Group in this Table and in Table III.XVII.

Table III.XXV details deaths by cause and month of receipt of information of the registration of such deaths.

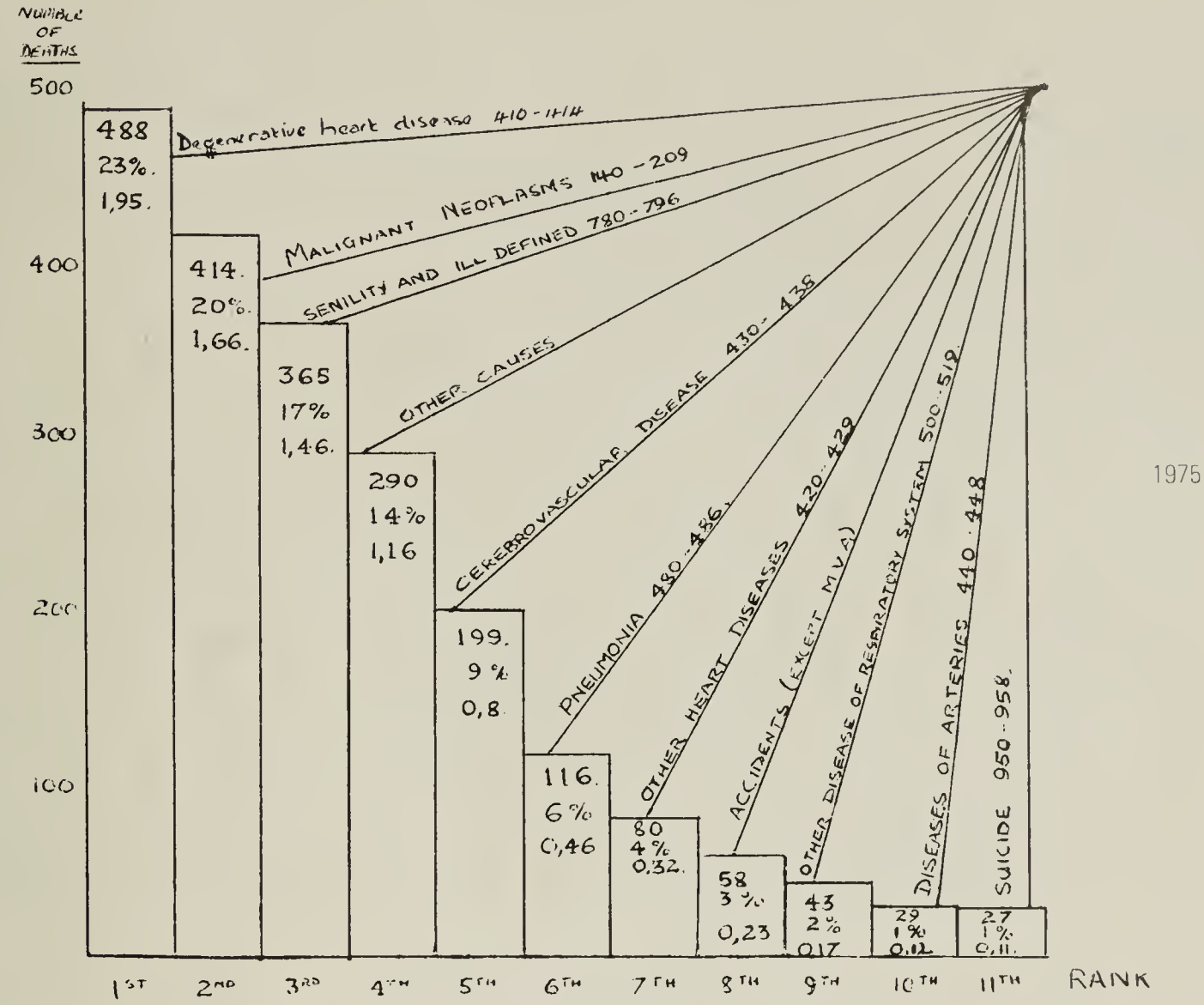
Table III.XXVI details cause specific death rates per 100 000 of the population by race for the period 1966 – 1976.

Deaths from coronary thrombosis have changed but little over a five year period in both Whites and Coloureds (see Table III.XXVII).

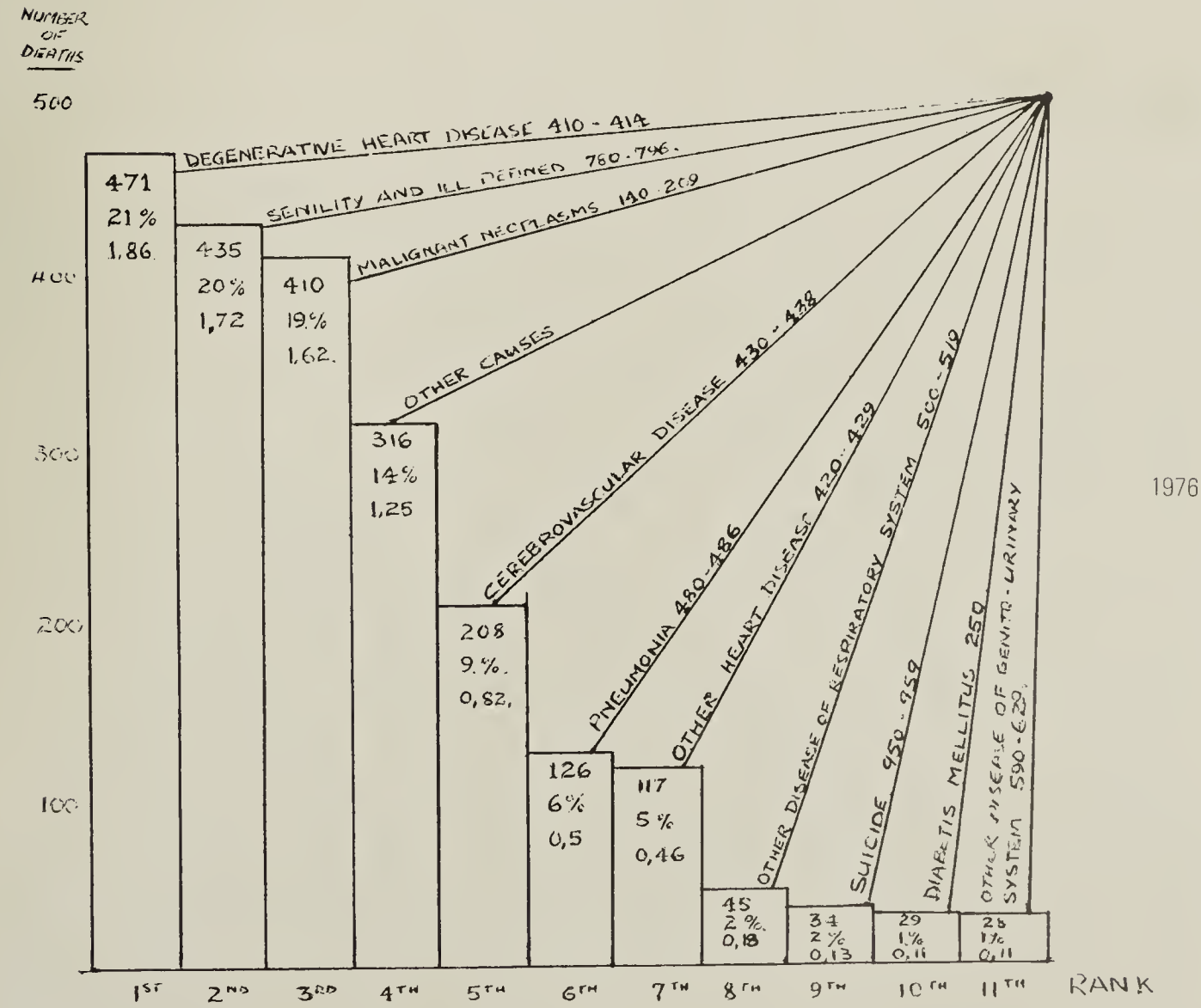
Mortality due to Tuberculosis is discussed in Section V (page 55) and that due to other notifiable conditions is discussed in Section VII (page 72).

Mortality due to non-notifiable communicable diseases is an important index of the priority to be attached to these conditions, as their morbidity is hard to quantify.

Figure: 3.6 *THE TEN PRINCIPAL CAUSES OF DEATH IN WHITE CAPE TOWN MUNICIPAL RESIDENTS 1975 AND 1976*

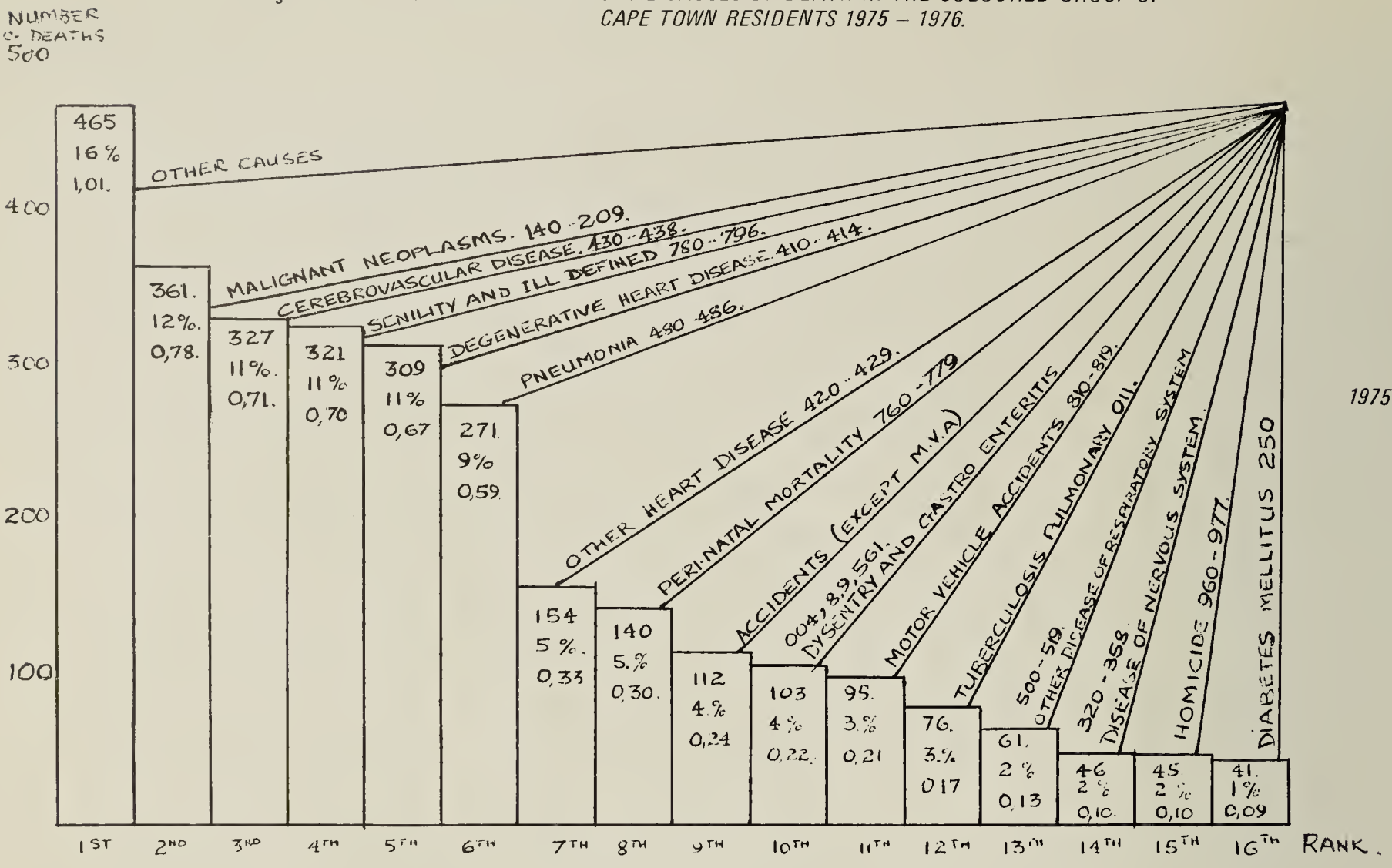


1975



1976

Figure 3.7: *THE FIFTEEN PRINCIPAL CAUSES OF DEATH IN THE COLOURED GROUP OF CAPE TOWN RESIDENTS 1975 – 1976.*



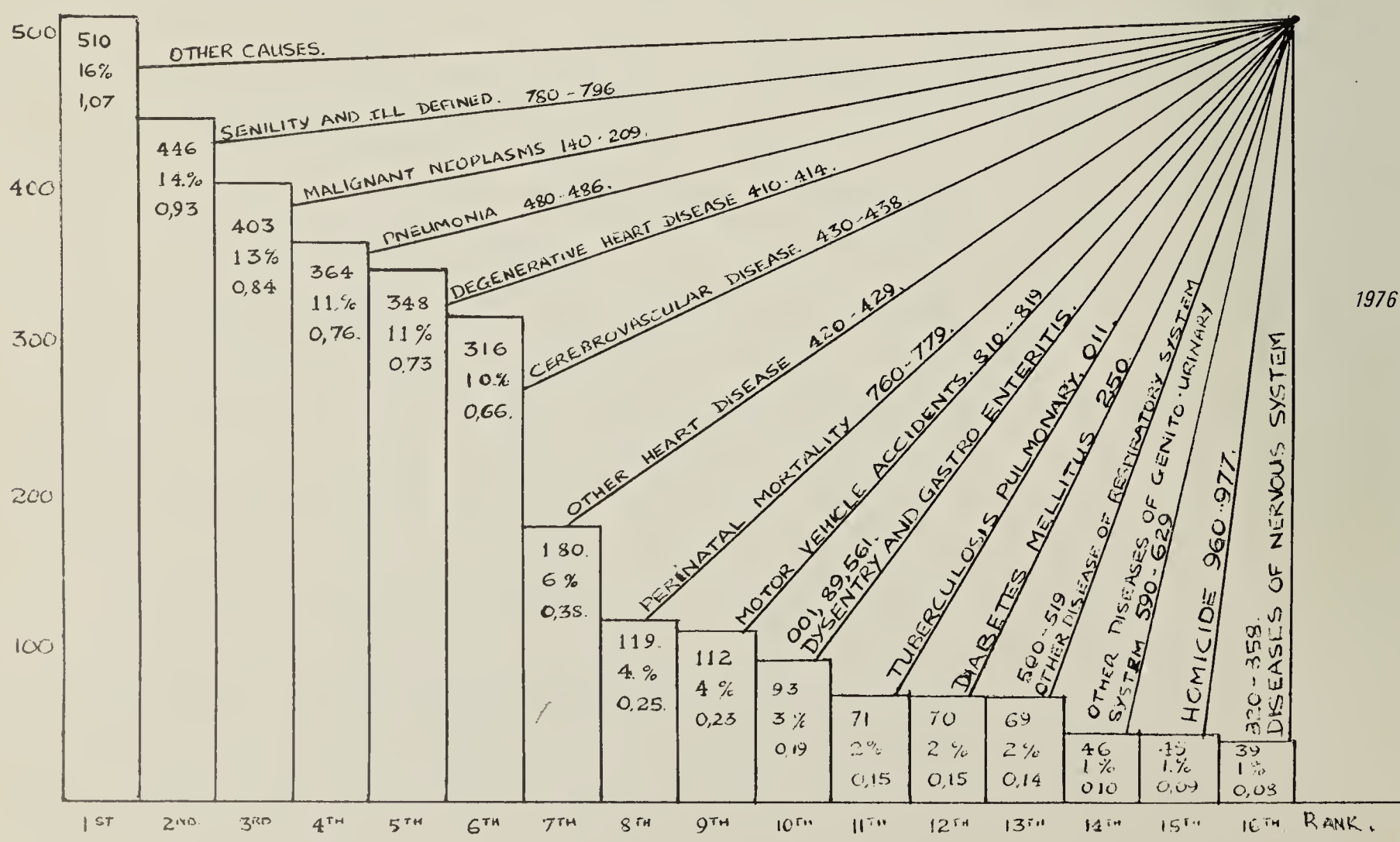
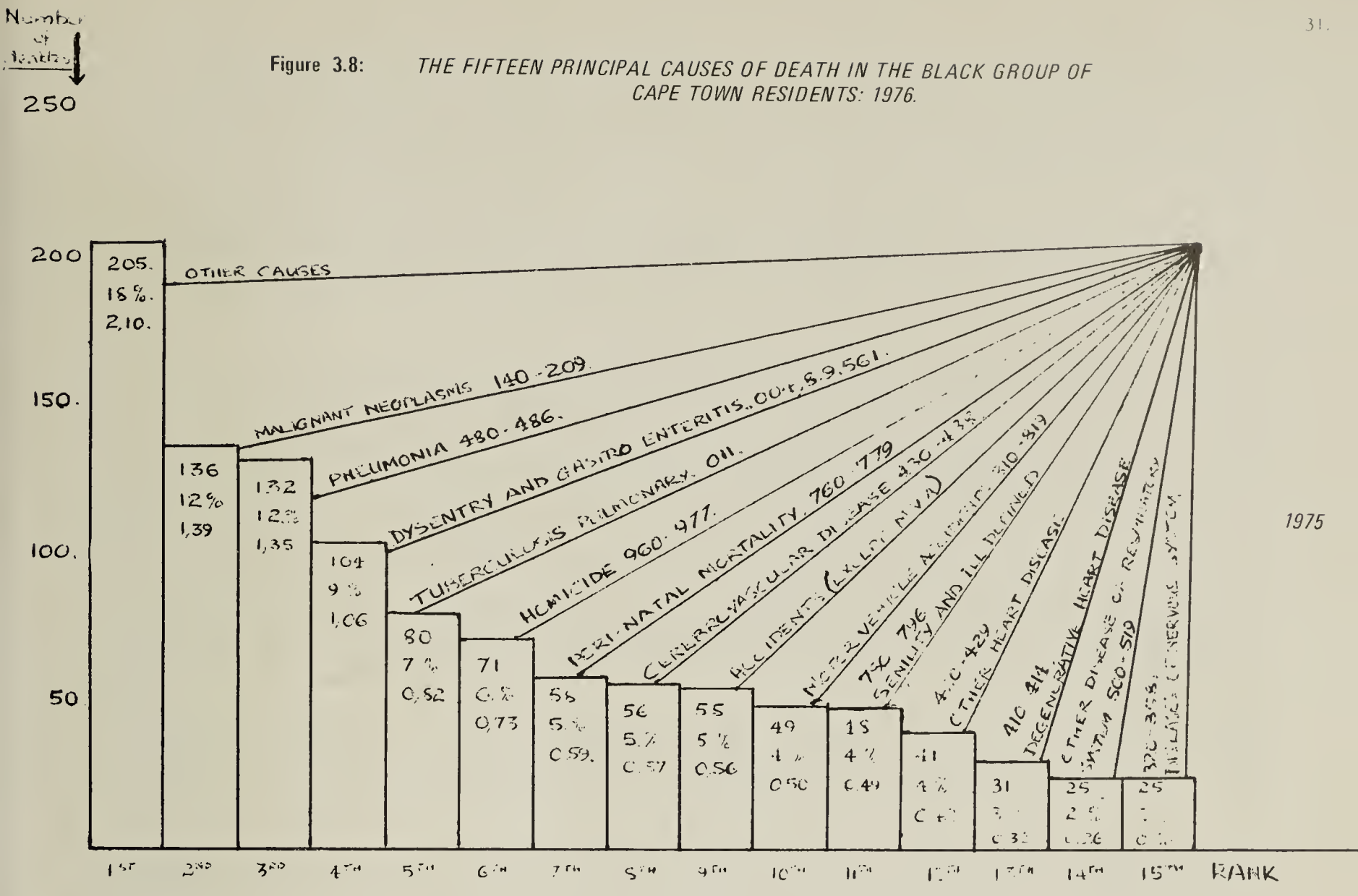
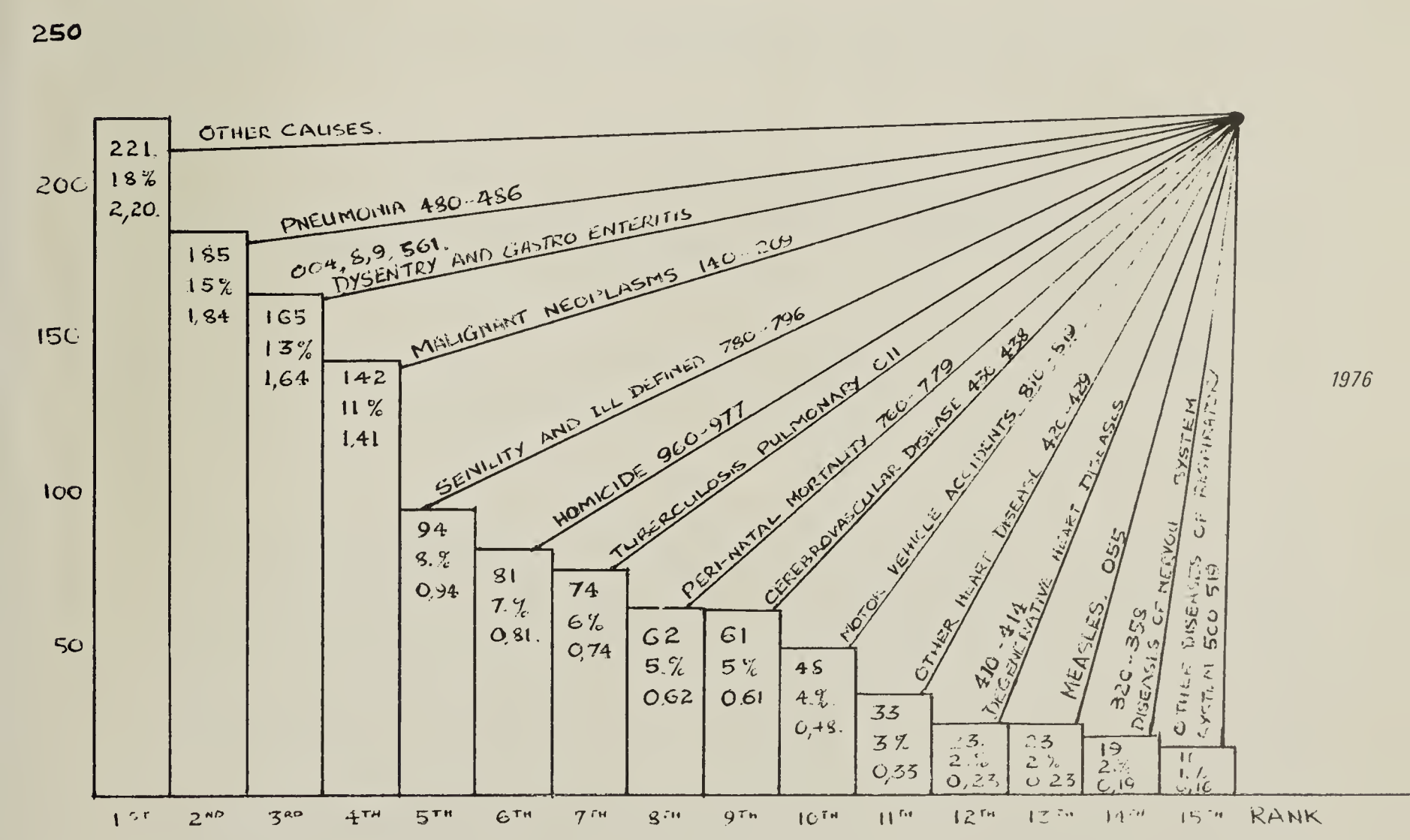


Figure 3.8: *THE FIFTEEN PRINCIPAL CAUSES OF DEATH IN THE BLACK GROUP OF CAPE TOWN RESIDENTS: 1976.*





Measles deaths over the ten years 1967 – 1976 are detailed in Table III.XXVIII. In 1976 there were 34 deaths (11 Coloured and 23 Black) compared with 27 deaths (10 Coloured, 1 White and 16 Black) in the previous year. The havoc wrought by this often underestimated 'Childhood disease' is a spur to continued preventive efforts (see page 91).

Deaths due to Influenza, bronchitis and pneumonia over the ten years 1967 – 1976 are detailed in Table III.XXIX. In 1976 there were 4 deaths due to influenza (1 White, 2 Coloured and 1 Black) 30 due to bronchitis (7 White, 15 Coloured and 8 Black) and 676 due to pneumonia (126 White, 364 Coloured, 185 Black and 1 Asian).

The importance of age is detailed in Table III.XXX wherein it is shown that 26^0/o of the combined Coloured/ Black/Asian deaths due to bronchitis or pneumonia occurred in infants aged less than one year, 7^0/o in children aged one or two years, 3^0/o in children aged 4 or 5 years and 64^0/o in persons aged 5 years or more. The comparable percentages in Whites were 3^0/o under one year, 1,5^0/o aged 1 or 2 years, 0,75^0/o aged 3 or 4 years and 94,75^0/o in persons aged 5 years or more. Infant mortality rates are discussed on page 33 .

The mortality due to various diarrhoeal diseases over the period 1967 – 1976 is detailed in Table III.XXXI. In 1976 there were 264 deaths due to these diseases (5 White, 94 Coloured and 165 Black) which was an increase over the 213 registered in 1975 (2 White, 105 Coloured and 106 Black). The death rate for the whole population in 1976 due to diarrhoeal disease was 31 per 100 000 population (2 White, 20 Coloured and 164 Black being the rates per 100 000 by race).

Eighty seven percent of these deaths occurred in children under the age of 5 years (186 under 1 year, 30 aged 1 or 2 years and 14 aged 3 or 4 years) and the diarrhoeal diseases were a prime cause of infant mortality (see page 36 , Table III.XXXII and Figure 3.13).

Accidental Deaths

The number of home accidents fell from 67 in 1975 to 57 in 1976 (Table III.XXXIII).

The number of accidental deaths increased from 379 in 1975 to 388 in 1976, the increase was largely due to the increase in road accident fatalities (by 20 from 174 to 194) and details are given in Table III.XXXIV.

Suicide

Data for the past five years (Table III.XXXV) does not show any marked change in the pattern of suicide which continues to affect particularly males and the 24 – 44 year old age group (Table III.XXXVI). There was an increased preference for carbon monoxide poisoning and railway deaths as modes of committing suicide. (Table III.XXXVII).

Deaths in Institutions

Table III.XXXVIII reveals that over half of all deaths took place in institutions in 1976.

Standardised Death Rates

The age-sex structure of a population has a profound effect on its mortality experience and renders crude death rates totally useless for comparative purposes. More detailed analyses of the Municipal population will be undertaken for future Annual Reports but as an example of the use of such statistics the Standardised Death Rates for White and Coloured males have been calculated (*) using the age-sex distribution illustrated in Figure 3.2 (1970 Census data) to calculate the population in the age groups 0 – 4; 5 – 24; 25 – 64 and 65 or more years. The Deaths occurring in these age groups were then used to calculate death rates therein and the population and crude death rate of the population of England and Wales in 1968 were used as the standard.

Whereas the crude death rates reveal that White males suffer a mortality of 9,6/1000 per year and Coloured males only 8/1000 per year the Standardised death rate for Whites was barely half that for Coloureds, i.e. 11,9/1000 as opposed to 22,3/1000.

The "comparative mortality factors" calculated from these rates (using a standard crude death rate of

12,4/1000)were Whites – 960; – Coloureds – 1798.

When more reliable demographic data becomes available it is anticipated that standardised Mortality Rates will be calculated to a much greater extent.

(*) Reference Hobson, W(Ed). 1969. The Theory and Practice of Public Health, 3rd Ed., Oxford, London.

MORTALITY IN THE VERY YOUNG

Mortality in the very young is a sensitive index of the efficacy of health services and the health status of communities and is therefore discussed as a special entity in this section of the report dealing with Deaths.

Ideally, mortality data for a complete spectrum of ages should be available, in respect also of race, sex and the cause of death. Data collection to date does not allow of so sophisticated a presentation as yet but in the paragraphs below special attention is paid to widely utilised rates which were defined on page 25.

Deaths in various age groups are detailed in Table III.XVII which includes data relating to children of pre-school and schoolgoing ages but this section of the report concentrates on deaths occurring before the age of one year, i.e. deaths occurring in infants.

Numbers of Infant deaths and Infant Mortality Rates (IMR) in general.

(see Tables III.II, III.XVII, III.XXXIX, III.XL, and Figure 3.9).

Black infant deaths increased markedly (by 36,6%) from 238 in 1975 to 325 in 1976 with a corresponding increase in the I.M.R. from 59 in 1975 to 79 in 1976. This disturbing fact is undoubtedly associated with the politico-socio-economic climate during the year under review.

White infant deaths fell by 17,5% from 40 in 1975 to 33 in 1976 with a corresponding fall in the I.M.R. from 12,2 in 1975 to 10,4 (the lowest ever recorded) in 1976.

Coloured infant deaths fell by 4% from 397 in 1975 to 381 in 1976 and there was a corresponding fall in the I.M.R. from 32,2 to 31,6 (also the lowest ever recorded).

Asian infant deaths fell from 2 in 1975 to 1 in 1976 and the I.M.R. fell from 8,3 to 3.8 – also the lowest ever recorded. However as the numbers of this population group are so small the rates cannot be regarded as comparable in validity to those for the other population groups.

The Infant Mortality experienced in Cape Town is discussed below in relation to the age at death, the season (month) in which deaths were registered, the principal causes of death, the association with illegitimacy and the place of death.

Age at death

(see Table III.XLI and Figure 3.9).

The usefulness of distinguishing between death rates at different ages lies in the ability to pinpoint causes which can be avoided – those causes being likely to differ as the child ages and is exposed to different hazards.

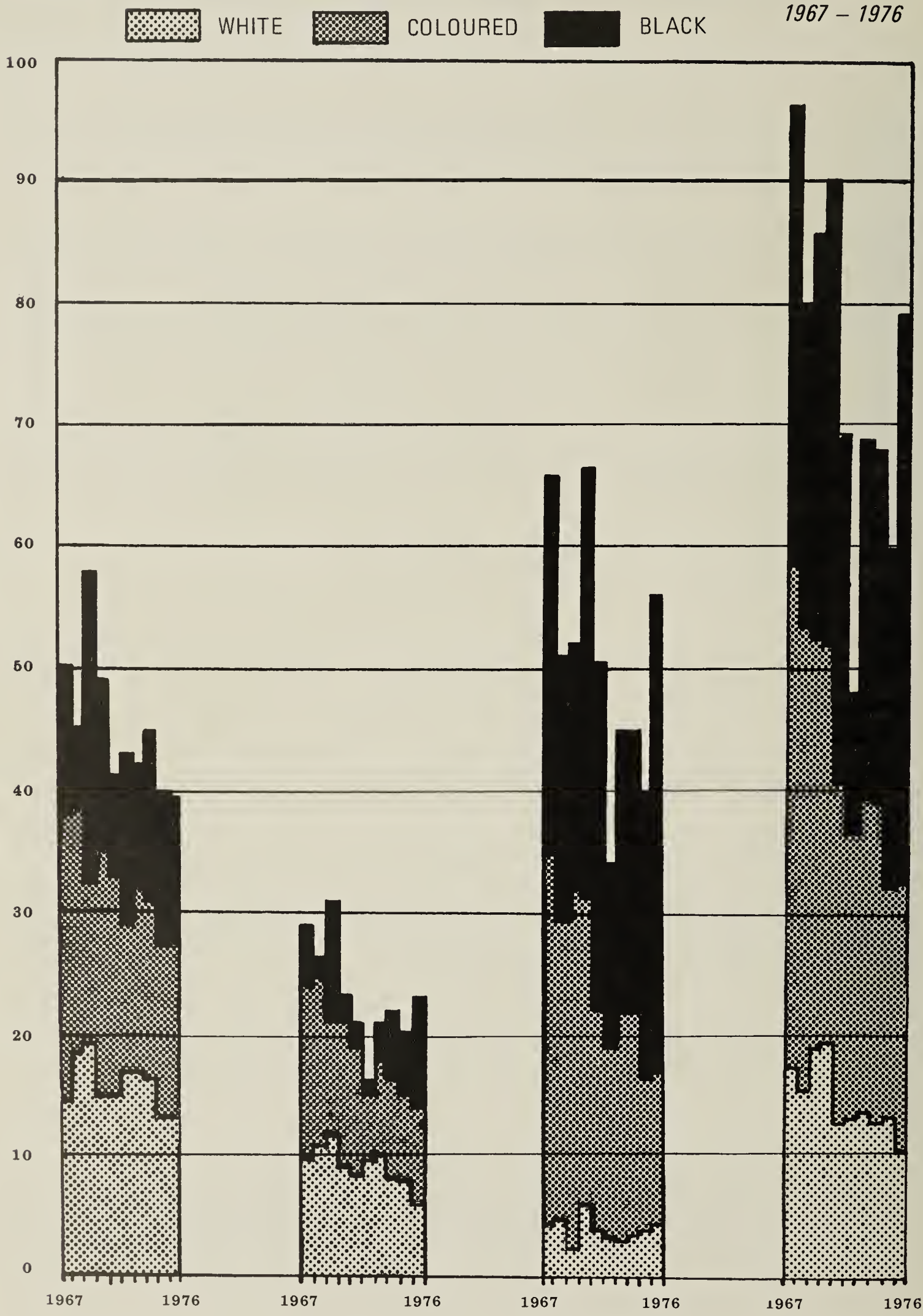
Perinatal mortality

This is usually regarded as an index of Obstetric care as it embraces both stillbirths and deaths of infants under one week of age; when factors relating to ante-natal care and to the delivery and immediate post-partum periods can be expected to have the most effect.

(Stillbirths were discussed on page 24).

There was very little change in perinatal mortality in 1976 compared with the previous year (see Table

Figure: 3.9 *PERI-NATAL, NEO-NATAL, POST NEO-NATAL AND INFANT MORTALITY RATES: 1967 – 1976*



Peri-natal Mortality (Still births and deaths under one week per 1000 live and still-births)

Neo-natal Mortality (Deaths in the first 28 days of life per 1000 live births)

Post Neo-natal Mortality (Deaths over the age of 28 days but less than one year per 1000 live births)

Infant Mortality (Deaths at less than one year per 1000 live births)

III.XLIX and Figure 3.9). White and Coloured rates were unchanged at 13 and 28 respectively; the Black rate fell from 40 to 38 and the Asian rate fell from 16 to 11.

Table III.L shows perinatal, neonatal and post-neonatal mortality over a five year period for Whites and other race groups.

Neonatal deaths

The neonatal period embraces the first 28 days of life and may be further subdivided into early (less than 7 days of life) and late (7 – 28 days) periods.

Early neonatal deaths

These are detailed on Table III.XLI which has not yet been refined to cover all race groups separately.

In Whites the 15 early neonatal deaths accounted for 45,5^{0}/o of all deaths under one year while for the other groups (Black/Coloured/Asian combined) the 206 deaths accounted for only 29% of infant deaths.

As regards perinatal mortality early neonatal deaths in Whites contributed 36,6^{0}/o in 1976 and 48,8^{0}/o in 1975 while stillbirths contributed 63,4^{0}/o in 1976 and 51,2^{0}/o in 1975, in the other race groups early neonatal deaths contributed 41^{0}/o in 1976 and 42,7^{0}/o in 1975 and stillbirths 59^{0}/o in 1976 and 57,3^{0}/o in 1975 of the total perinatal mortality.

Late neonatal deaths

(see Table III.XLI).

These numbered only 5 for Whites and 61 for other race groups, I.E. 15^{0}/o and 8,6^{0}/o of White and other infant deaths respectively.

Neonatal deaths –combining the above

(see Figure 3.9 and Tables III.XLI and III.XLIX).

There was an increase in the Black neonatal mortality from 81 deaths in 1975 to 94 deaths in 1976 corresponding to an increase in the neonatal mortality rate from 20 to 23. The number of Asian deaths (1) and the neonatal mortality rate (4) remained unchanged from 1975 to 1976. White deaths fell from 27 to 20 and the rates fell from 8 to 6 while Coloured deaths fell from 183 to 172 and their rates from 15 to 14; continuing the trends for these two groups.

Post Neonatal Deaths

(From one month but under one year of age)
(see Table III.XLI, III.XLIX and Figure 3.9).

Ideally, health services and socio-economic conditions should be such that mortality in this period is minimal. The hazards of delivery and the post-partum period are past, the waning of maternal immunological protection should be paralleled by a programme of active artificial immunisation and in general only "unavoidable" causes of death should operate.

This situation is approached for the White group where in 1976 there were only 13 such deaths (a rate of 4 per 1 000 live births) of which possibly half were "avoidable".

Asians too had a rate of 4 per 1 000 (one death). The Coloured infants however suffered 209 deaths (compared with 213 in 1975) with a rate of 17 in 1976 as in 1975.

The Black group experienced 231 deaths (compared with only 158 in 1975 – an increase of 46^{0}/o) with an increase in the death rate from 39 in 1975 to 56 in 1976.

The causes of Black and Coloured deaths are discussed below but probably two thirds of them were readily

'avoidable' (see Table III.XLI).

Deaths by season

The same problem with data collection discussed on page 25 apply. Month of Receipt of registration of deaths is detailed in Tables III.XLV and III.XLVI.

Principal causes of Infant Mortality

(see Tables III.XVII, III.XLIV, III.XLVI and Figures 3.10, 3.11 and 3,12).

Infant Mortality in general

From Table III.XLI which lists 21 diseases or groups of diseases it can be seen as in Figure 3.10 that in Whites the major single problems are prematurity, congenital anomalies and pneumonia.

Figure 3.11 shows that in the Coloured group the major single problems are prematurity, pneumonia, gastro-enteritis and congenital malformations and Figure 3.12 shows that in Black group the major single problems are gastro-enteritis, pneumonia, prematurity, measles and congenital malformations. Figure 3.13 illustrates trends in gastro-enteritis mortality.

Table III.XLIII indicates trends over a decade. It is pertinent now to examine causes of death in relation to the age at death so that efforts by the appropriate health services can be focussed thereon.

Early neonatal mortality

In Whites the 15 early neonatal deaths were due to prematurity (10), congenital anomalies (3), haemolytic disease of the newborn (1), and 'other causes' (1). Preventive measures here need to be directed chiefly towards determining and avoiding the reasons for prematurity which should be a priority for those concerned with ante-natal care and deliveries.

In Coloureds and Blacks grouped together as on Table III.XLI (future refinement of data collation will separate these two groups) the 206 early neonatal deaths were due to prematurity (114), other infant diseases (32), other or ill-defined causes (22), congenital malformations (11), pneumonia (7), septicaemia (6), diarrhoea/enteritis (5), meningitis (3), postnatal asphyxia/atalectasis (2), injury at birth (2), congenital syphilis (1) and accidental mechanical suffocation (1).

Here again the clear priority for health services concerned with ante-natal and delivery services must be to prevent prematurity. In these race groups there is also, however, a much wider spectrum of pathology involved.

It is noteworthy how unimportant is gastro-enteritis at this period of the child's life – almost certainly because of breast feeding, or at least bottle – feeding under institutional supervision.

Late neonatal mortality

In Whites the 5 deaths were due to 'other causes' (2), gastro-enteritis (1), measles (1), congenital anomalies (1).

In Coloureds and Blacks grouped together as on Table III.XLI the 61 late neonatal deaths were due to prematurity (16), pneumonia (10)*, other or ill-defined (9)*, congenital anomalies (8), gastro-enteritis (7)*, bronchitis (3)*, other infant diseases (3)*, septicaemia (2)*, meningitis (1)*, congenital syphilis (1), postnatal asphyzia atelectasis(1).

Here the health services usually caring for the infant upon its return to the home can hope to prevent only a proportion of those 36 deaths marked *, the ante-natal and delivery services still needing to prevent the remainder at an earlier stage.

Post neonatal deaths

In Whites the 13 deaths were due to 'other or ill-defined causes' (5), pneumonia (4), congenital malformations

Figure 3.10: *PRINCIPAL CAUSES OF INFANT MORTALITY IN WHITES: 1976.*

Rank	Code	Cause	Deaths
1	777	Prematurity	10
2	—	Other Misc. causes	8
3	740-759	Congenital Malformations	7
4	480-486	Pneumonia	4
5	055	Measles	1
6	267-273	Nutritional Maladjustment	1
7	774/775	Haemolytic & Haemorrhagic	1
8	004,8,9 561	Gastro-enteritis	1
		All causes	33

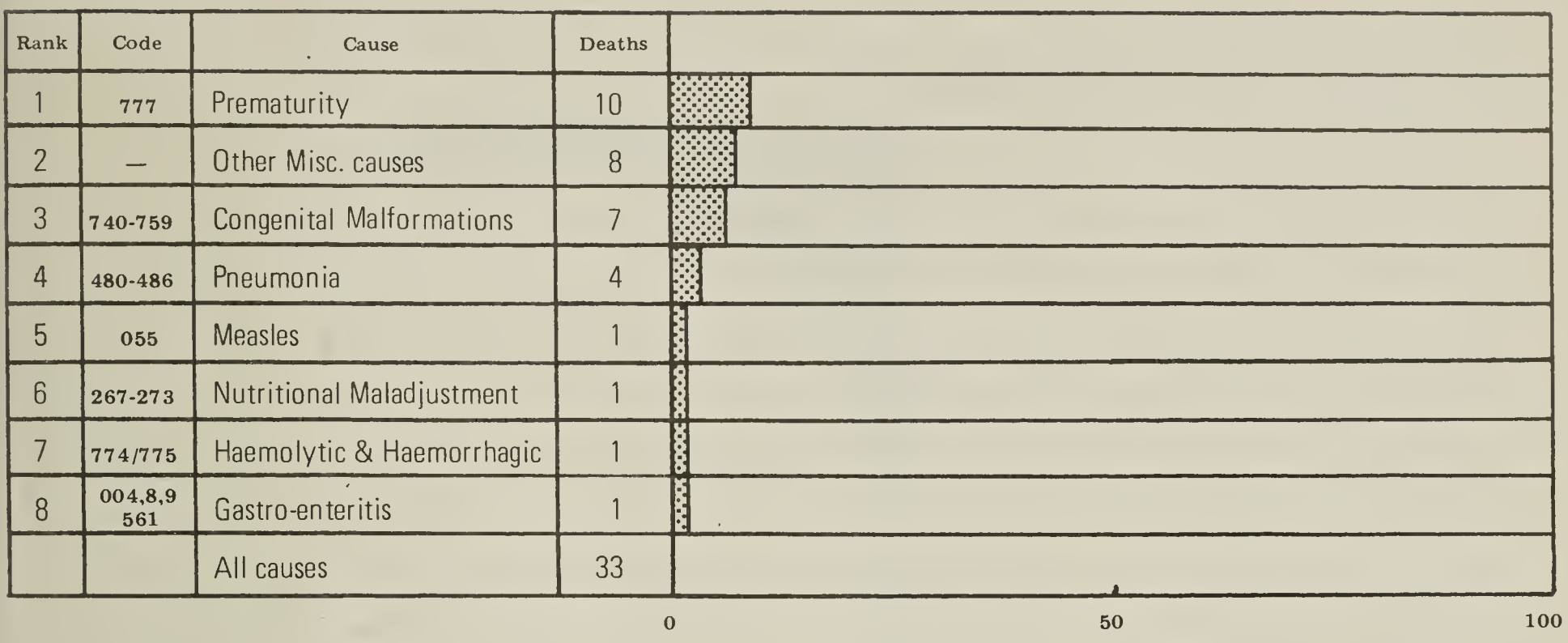


Figure 3.11: *PRINCIPAL CAUSES OF INFANT MORTALITY IN COLOUREDS: 1976*

Rank	Code	Cause	Deaths
1	777	Prematurity	91
2	480-486	Pneumonia	82
3	—	Other Misc. causes	73
4	004,8,9 561	Gastro-enteritis	64
5	776/778	Other diseases of early infancy	20
6	740-759	Congenital Malformations	20
7	038	Septicaemia	8
8	320	Meningitis	6
9	267-273	Nutritional Maladjustment	6
10	055	Measles	3
11	500-519	Other diseases of Respiratory tract	3
12	466 490,491	Bronchitis	3
13	772	Birth injury	1
14	013	T B Meningitis	1
		All causes	381

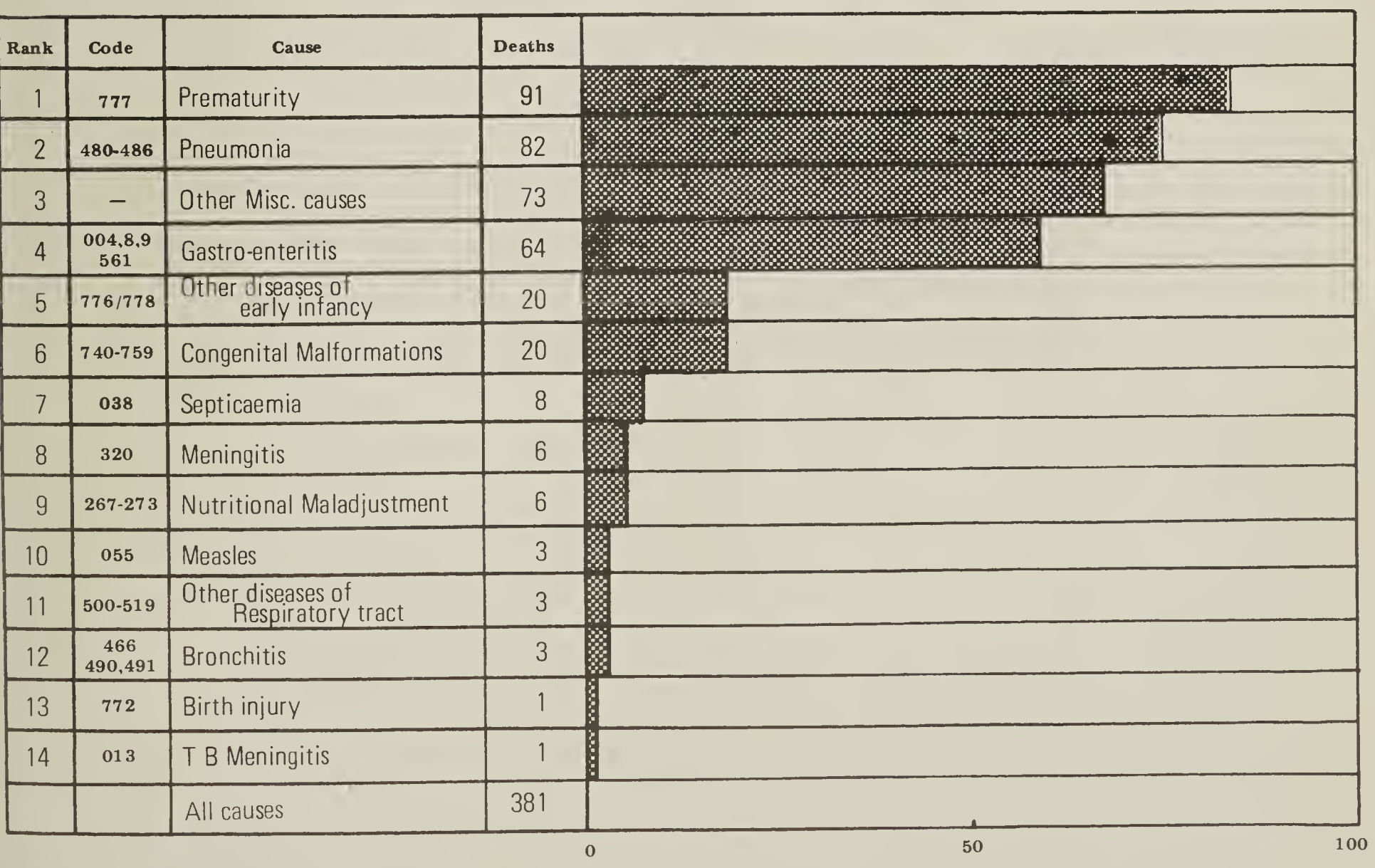


Figure 3.12: *PRINCIPAL CAUSES OF INFANT MORTALITY IN BLACKS: 1976*

Rank	Code	Cause	Deaths
1	004,8,9 561	Gastro-enteritis	126
2	480-486	Pneumonia	57
3	777	Prematurity	44
4	—	Other Misc. causes	32
5	776/778	Other Diseases of early infancy	16
6	055	Measles	14
7	740-759	Congenital Malformations	7
8	320	Meningitis	5
9	466 490,491	Bronchitis	5
10	010-012 015-019	Tuberculosis	5
11	038	Septicaemia	4
12	267-273	Nutritional Maladjustment	2
13	090	Syphilis	2
14	500-519	Other Diseases of the Respiratory tract	2
15	259-266	Avitaminosis	1
16	772	Birth injury	1
17	013	T B Meningitis	1
18	E913	Suffocation	1
		All causes	325

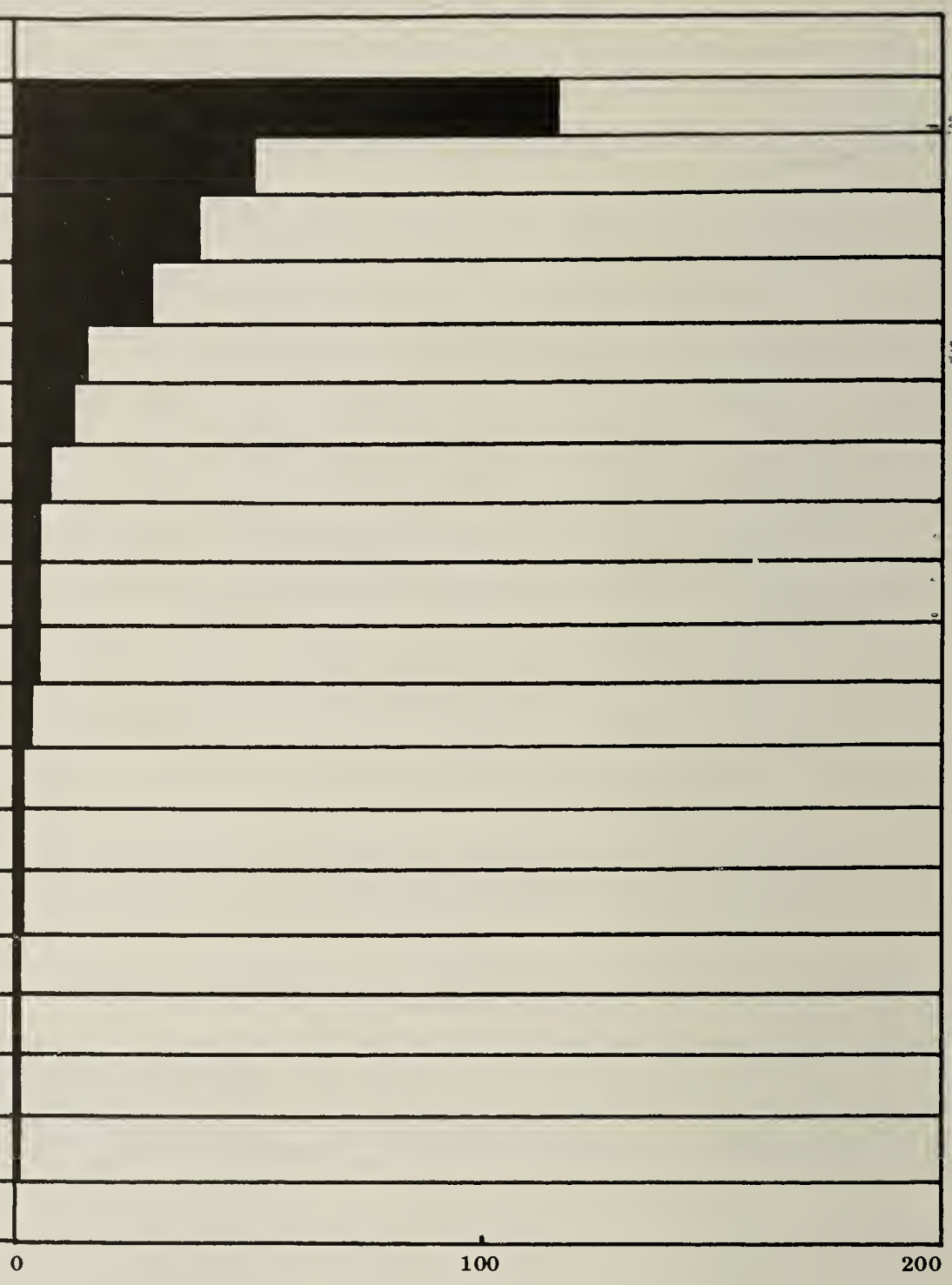
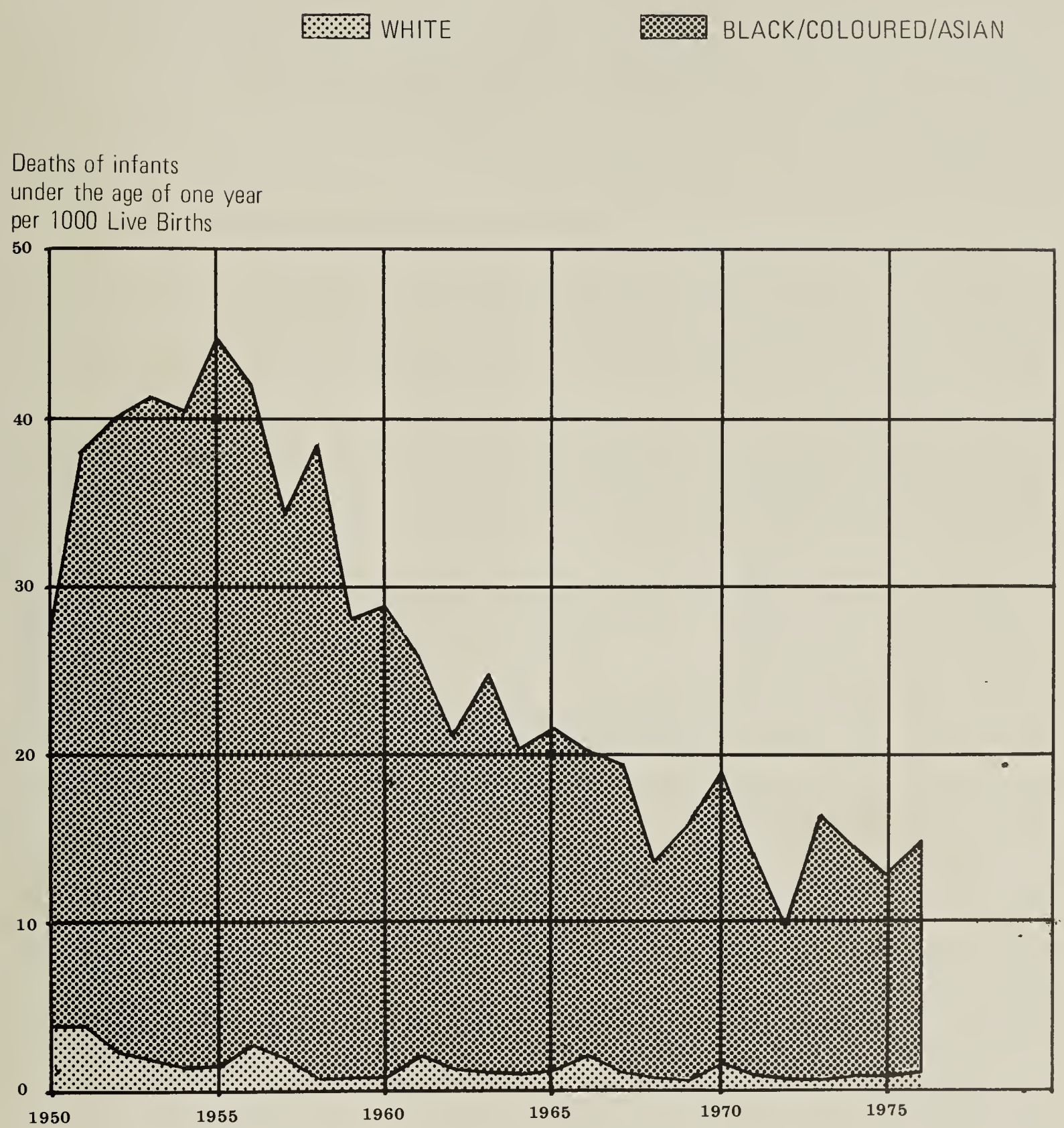


Figure 3.13: *INFANT MORTALITY DUE TO GASTRO-ENTERITIS IN CAPE TOWN: 1950 – 1976*



(3) and nutritional maladjustment (1). Data Collation needs to be more precise but it would appear that preventive services are good and the chances of improvement slight.

In Coloureds and Blacks taken together as a group the 440 post-neonatal deaths were due to gastro-enteritis (180), pneumonia (120), other and ill-defined causes (74), measles (17), congenital anomalies (9), meningitis (9), nutritional maladjustment and avitaminosis (7), tuberculosis (7), prematurity (5), bronchitis (5), septicaemia (4), post-natal asphyxia/atelectasis (2), other infant diseases (1).

Community preventive health services should view gastro-enteritis and pneumonia as a major problem to be investigated and overcome; and to regard almost all post neonatal deaths as preventable and thus as failures of health and social services.

Infant Mortality in relation to Legitimacy

It must be remembered that legitimacy rates are widely different for the different race groups and that associations between legitimacy and infant mortality or indeed race and infant mortality, are in many cases spurious as there are other socio-economic and enviromental factors involved.

Table III.XLVIII gives infant mortality rates by race and legitimacy for 1976 and 1975 **only** for deaths of infants whose legitimacy was known. (265 infants deaths where this could not be established are excluded from the table). In general the infant mortality rate is twice as high amongst illegitimate births as amongst legitimate ones in the Coloured and Black Groups.

Infant deaths and place of death

Table III.XLVII details the number of deaths in each race group occurring in hospital or at home by neonatal and postneonatal periods and by legitimacy.

83,3^{0}/o of neonatal deaths took place in hospital while only 50^{0}/o of post-neonatal deaths did so, probably indicating a failure of parents to utilise health services quickly enough.

85,4^{0}/o of known legitimate neonatal deaths took place in hospital as did an almost equal percentage of 84,6^{0}/o of such illegitimate deaths.

Somewhat surprisingly whereas 49,6^{0}/o legitimate post-natal deaths took place in hospital, the illegitimate figure was slightly higher at 51,7^{0}/o.

Where legitimacy was not known, 80,3^{0}/o of neonatal deaths occurred in hospital and 48,7^{0}/o of postnatal deaths did so.

MATERNAL MORTALITY

(see Table III.LI)

There were 9 maternal deaths in 1976, one being ascribed to childbirth and 8 to abortion. Magisterial inquests were held in 4 cases of abortion. The maternal mortality rate was the highest in the past five years (see Table III.LII).

VITAL STATISTICS COMPARED WITH OTHER CENTRES

Table III.LIII details such comparisons for a number of centres.

SECTION IV

COMMUNITY HEALTH CARE

This Branch is responsible for providing promotive and preventive health services in the spheres of Family Planning; Ante-Natal and Post-Natal Care; and Child Welfare (Immunisation, development screening, screening for hearing and visual defects, school eye clinics, infant feeding advice and distribution of subsidised milk, protected infant care, nursery school licensing, and control of Council Nursery Schools). In addition, Tuberculosis, Geriatric and Venereal Disease services are offered at Comprehensive Community Health Centres. (see below).

Health education is provided in (and in-service staff training covers) all the above fields.

The Branch's responsibilities are met by a combination of clinic services at fixed centres and an intensive programme of domiciliary visiting by Public Health Nurses (Health Visitors).

COMPREHENSIVE COMMUNITY HEALTH CENTRES

Personal Health Services offered by the City Health Department developed along lines dictated by legislation (or the lack of it) and the needs of the community so that separate branches dealing with Tuberculosis, Venereal Diseases and Maternal and Child Welfare emerged over the years. Because of the realisation that greater efficiency, improved work satisfaction and a higher level of community service would result from the amalgamation of these services into a more comprehensive, single personal health service, such a pilot project was launched in the Heideveld area in 1974. Since then continuous progress has been made towards the ultimate complete fusion of these three Branches. Delivery of this health care is by means of units consisting of a base clinic or Community Health Centre providing a wide range of services to meet the needs of the residents of a defined surrounding area.

By the end of 1976 Heideveld, Silvertown, Retreat, Lavender Hill and Kensington were offering comprehensive promotive and preventive Health Services to some 241 000 people.

A planning committee involving the field staff meets regularly to blueprint all stages of the conversion of each centre.

FAMILY PLANNING

Programme Aims

Family Planning Services are being accorded an ever higher priority rating as many Health problems would be prevented or alleviated if family size was limited to that desired by (and capable of being provided for by) the parents. The Central Government attaches so much importance to this service that it is subject to a 100% refund from that body. It must be emphasized that the aim of the Family Planning Programme is to raise the standard of Family Health and not merely to control population or community growth.

Attendances

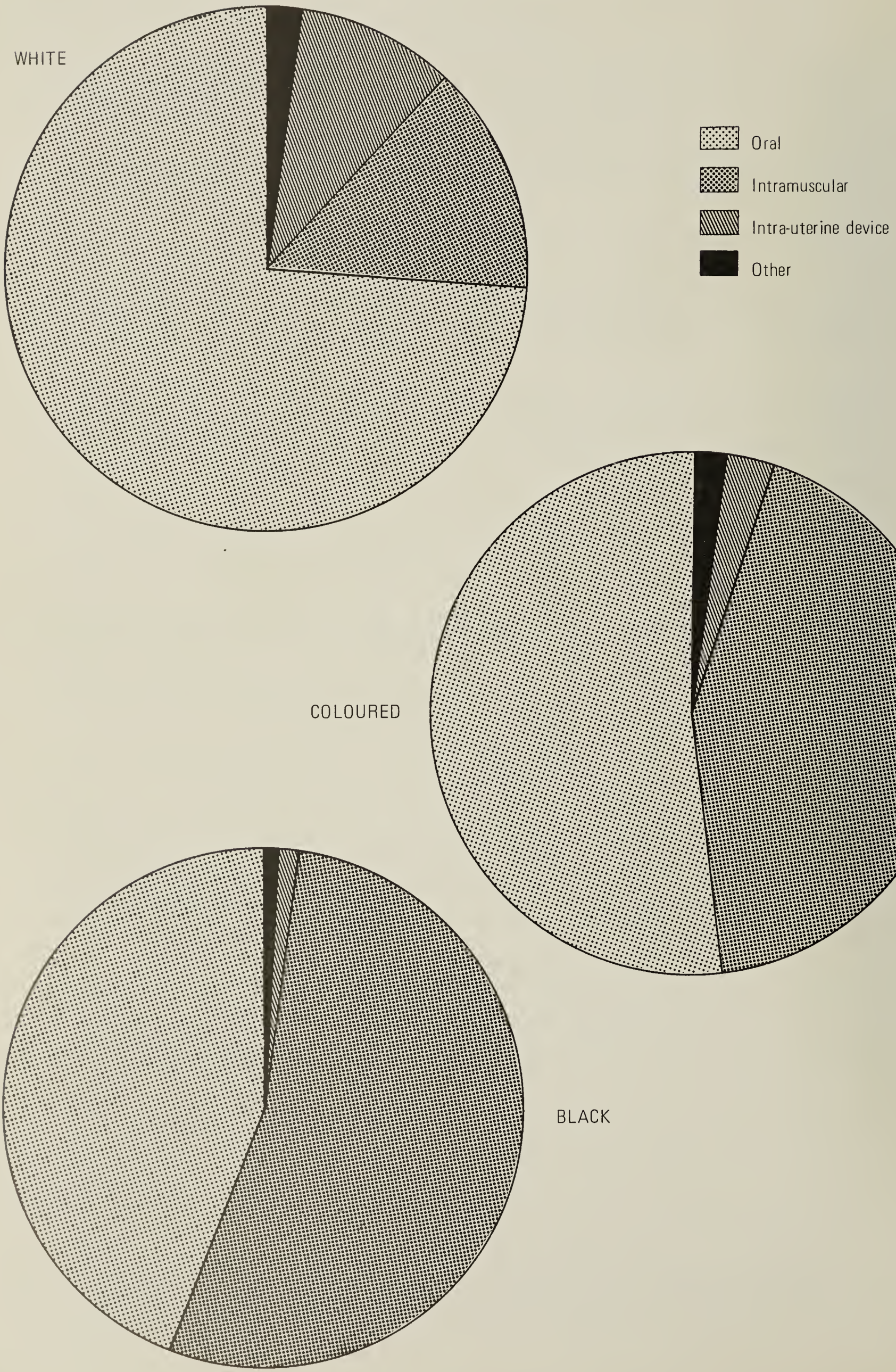
In 1976 a total of 40 755 persons (2 572 White, 32 993 Coloured and Asian and 5 190 Black) made use of the services (see Table IV.I) which is higher than the previous year but not as high as the record set in 1974 (although the ratio of "Visits made : individual persons" was much better in 1976 than 1974, namely 3,13 : 1 versus 2,31 : 1).

Individual persons attending ("Attendances") at 22 centres and at clinics held by the Factory team over the years 1974 – 1976 are detailed in Table IV.II.

The preferences for different modes of contraception shown by women of different race groups is shown in Table IV.III and Figure 4.1.

The percentage of White and Coloured females in the child-bearing age group (15 – 49 years) estimated to be attending Family Planning clinics is shown in Table IV.IV. For Whites the figure is 4% and for Coloureds 27%. Many White women, of course, seek the advice of their private doctors. Black figures

Figure 4.1: *THE PREFERRED INITIAL MODE OF CONTRACEPTION: 1976*



cannot be calculated owing to the lack of demographic data.

Carcinoma of the cervix uteri

Since February 1960, routine cytological screening to detect possible early malignancy of the cervix has been performed on all women attending Family Planning or Post-Natal clinics. Where atypical cytology is found the patients are referred to the gynaecological out-patients Department for further management.

In 1976, 12 555 Papanicolau smears were examined, 129 results were reported as 'atypical' and were investigated – of these, early carcinoma was discovered in at least 41 cases (investigations are proceeding in some of the remainder).

ANTE-NATAL AND POST-NATAL CARE

Municipal staff do not undertake any direct part in the management of parturition per se but are involved in providing health care both before and after delivery to many persons, and in supervising private midwives who do manage parturition in a minority of the total number of deliveries taking place annually.

Ante-Natal Care

The Health Department works closely with the Provincial and private maternity Services operating in the Peninsula, referring many cases to the former and assisting with ante-natal care in some of the latter.

Attendances

During 1976 the fall in ante-natal attendances evident since 1974 continued (from 1967 – 1974 the annual average attendance was 44 397, this fell by 23%o in 1975 to 33 827 which in turn fell by 23%o in 1976 to 25 988).

The fall in attendances is almost entirely due to the greater number of referrals to the Peninsula Maternity Services group of hospitals and Day Hospitals although there was also a fall in the numbers of births (i.e. also of conceptions). See Figure 4.2.

During 1976 there were 876 clinic sessions held at 17 different centres (see Tables IV.V and IV.VI), although it should be noted that at the comprehensive Community Health Centres (Heideveld, Silvertown, Retreat, Lavender Hill and Kensington) it is possible for ante-natal patients to be attended to outside of the listed clinic session hours.

Private midwives were booked to attend 2 922 domiciliary deliveries (650 fewer than in 1975) and the majority of these expectant mothers attended Municipal ante-natal clinics – the midwives being encouraged to attend with their patients for consultation with the doctor.

There were 11 933 first attendances of new ante-natal cases (compared with 13 625 in 1975), but the majority attended only once and were then managed by the Provincial Maternity Services.

Blood tests

Serological screening (V D R L tests) for syphilis is done at the State Laboratory on samples submitted from the ante-natal clinics on most persons (except where further ante-natal care is to be provided by the Provincial Hospitals) and 4 077 such specimens were submitted in 1976 (8 Whites and 4 069 either Coloured, Asian or Black). Of these 655 were reactive to some degree (16%o).

Blood is also sent to the Blood Grouping Laboratory of the Provincial Administration for A, B, O and Rhesus grouping and for haemoglobin estimation on all patients not already referred to other centres.

Midwifery

While not offering facilities for delivery at Municipal clinics the Department does supervise all persons other than medical practitioners practising midwifery in the Municipal area (in terms of Section 18 (b) of the Public Health Amendment Act, Act No. 15 of 1928).

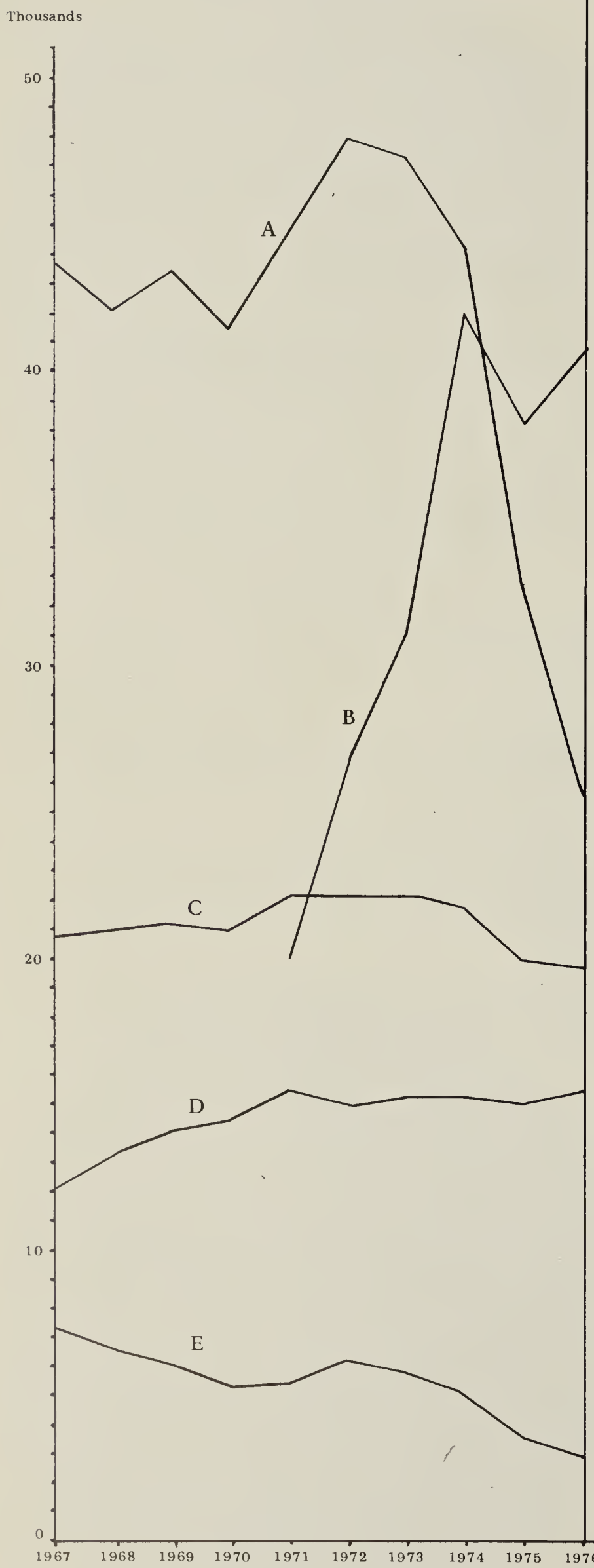


Figure: 4.2 *THE RECENT FALL IN ANTE-NATAL CLINIC ATTENDANCES DISPLAYED IN RELATION TO THE NUMBER OF NOTIFIED BIRTHS, ATTENDANCE AT FAMILY PLANNING CLINICS,* THE NUMBERS OF BIRTHS IN INSTITUTIONS AND THE NUMBER OF CONFINEMENTS BOOKED WITH PRIVATE MIDWIVES: 1967 – 1976*

(*from 1971 only because of changes to data collection)

A = Total attendances at ante-natal clinics

B = Individuals attending Family Planning clinics

C = Notified Births

D = Births in institutions

E = Confinements booked with Private Midwives

There are 47 private midwives (45 trained midwives and 2 untrained 'gamps' who are registered with the S.A. Nursing Council) and 34 provincial district midwives being so supervised.

Regular monthly meetings are held at various centres which afford the private midwives the opportunity of hearing lectures given by Obstetricians from the Medical School, University of Cape Town and at which the supervisor of midwives inspects the midwives records and equipment.

During 1976 the supervisor of midwives made a total of 561 visits including those to 15 premature, 74 jaundiced (who were admitted to hospital if necessary after blood was examined for bilirubin) and 18 ophthalmia neonatorum cases; 94 visits to midwives in their own homes and 15 inspections held at meetings. One midwife was interviewed at the office and 345 general Community Health visits were made.

Private midwifery fees are paid by the Department for approved indigent cases in areas not served by the Provincial District Midwives or midwives from the training school. An amount of R84 was so paid in 1976.

Post-Natal Care

Post-natal care is provided at Family Planning sessions (see above).

CHILD WELFARE

Scope of activities at child welfare sessions

During 1976 at most of the centres offering child welfare and immunisation sessions these and Family Planning were combined in a single session (at the end of the year only Bloemhof, Elfindale, Wynberg and Parkwood continued to offer separate sessions).

At such clinic sessions mothers are advised on correct feeding practices and hygiene matters relating to infants and pre-school children. Dried milk is supplied as discussed below.

Neonates are medically screened for abnormalities and all babies attending child welfare are periodically screened for developmental anomalies.

Attendances at Child Welfare sessions

There has been a decline in the total number of attendances at child welfare clinics recently. The average annual attendances 1967 – 1974 was 346 366, this fell by 11^{0}/o in 1975 to 307 214 which fell in turn by 4,7^{0}/o to 292 792 in 1976 (see Table VI.VII). The clinics showing the greatest drop were those particularly affected by the civil unrest (the Guguletu III clinic was razed by fire on 1976–08–10); the Group Areas Act (Wesley Street clinic was closed in September due to the decreased population to be served in that area consequent upon the Group Areas Act; Aspeling Street and Bloemhof lie in a severely depopulated area); or by the amalgamation of clinics (Athlone, Bokmakierie and Silvertown were amalgamated into the latter).

The last named item led to concern as the average attendance 1967 – 1974 was 44 907 which fell by 20^{0}/o to 35 877 in 1975 and then by 8,5^{0}/o to 32 817 in 1976 (both falls were higher than the city average) and as part of the on-going evaluation of the Community Health Care concept certain changes (e g additional time to be spent on child health versus Geriatric/Tuberculosis/V D home visiting) were made to the modus operandi. This area remains rather large and the centre is unfortunately poorly sited so that there remains some resistance (induced by transport costs) to more than a bare minimum of trips to the clinic on the part of the mothers from Bokmakierie area in particular. This matter is continually under review.

The number of sessions held (see Table IV.VI) was 3 817 and of the 292 792 attendances recorded, 17 830 were new attenders (17 420 being aged less than one year of which 2 487 were White and 14 933 were Coloured/Black or Asian).

The new attendances of White infants under one year of age was equivalent to 77,3^{0}/o of the total number of White births notified during 1976 and for all other races combined the percentage of such Notified births represented by new infant attendances was 88,4^{0}/o (in 1975 these two percentages were 65,7^{0}/o and 92,4^{0}/o respectively). Separate Immunisation sessions resulted in many more infants attending clinics, as given on page 46.

A voluntary centre, the South African Mothercraft Training Centre (Lady Buxton Home) held 376 sessions at Bowwood Road Claremont (470 new infants attended and there was a total of 4 373 attendances) and 10 sessions at Meadowridge which closed down early in the year (6 new infants attended; there was a total of 75 attendances).

Immunisation

A continued effort to keep up the community level of immunity to poliomyelitis, diphtheria, whooping cough, tetanus, smallpox, tuberculosis and measles was made in 1976 as in previous years.

The recommended schedule of the State Health Department (form Health 183) is followed in broad outline (see Table IV.VIII).

Immunisation is offered by:–

(a) the child welfare staff at the vast majority of clinics as already indicated.

(b) an immunising team of nurses who visit clinics, institutions and schools.

A sophisticated mailing system (whereby postcards are addressed to parents once the infant has attained the age of three months, and which detail the need for immunisation by private doctors or at a municipal clinic) is made possible by reference to the records of birth Notification (see page 23).

a) Poliomyelitis

Government Notice R 1989 of 1963–12–27 made it compulsory for immunisation against poliomyelitis to be commenced within the three months after a child had attained the age of three months and to be complete within a period of twelve months from the date of the first dose. Immigrants were also prescribed as needing to be immunised and the service was proclaimed to be available free of charge to South African citizens and immigrants alike. Such free immunisation is available at special weekly sessions at 'Libertas' building as well as at all clinics where triple vaccine (D W T) is routinely administered.

Poliomyelitis immunisation was offered at 1019 sessions (43 at school, 41 at other institutions and 935 at child welfare clinics) during 1976 and a total of 66275 doses were issued (broken down by whether 1st, 2nd, 3rd or booster dose; by age group and by White or Black/Coloured/Asian recipents in Table IV.IX (a)). Figure 4.3 illustrates the number of complete triple dose poliomyelitis immunisations administered in relation to the number of births Notified over a five year period (1972 – 1976).

b) Diphtheria, Whooping Cough (Pertussis), and Tetanus Vaccine (D W T; D P T or "triple antigen")

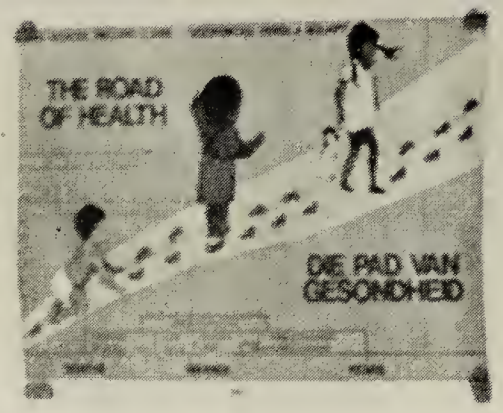
Such immunisations are not compulsory but are vitally important to the health of the child. The triple antigen in use in 1976 was that of the S A I M R and its administration is recommended at 3 months, 4 1/2 months and six months of age with a further booster dose at 18 months. Use of D T alone is advised for school entrants.

At 1 031 immunisation sessions (86 at schools, 50 at other institutions and 895 at child welfare centres) in 1976 a total of 88 776 injections of various combinations of D ± W ± T were administered (see Table IV.IX (b) and (c)).

First attendances in the under 1 year age group were equivalent to 97% of the Coloured/Asian/Black births Notified during the year and to 94% of White Notified Births (comparable percentages in 1975 were 94% and 84%). The increase in White attendances was particularly noticeable as the group has in the past made much more use of private medical practitioners for this purpose.

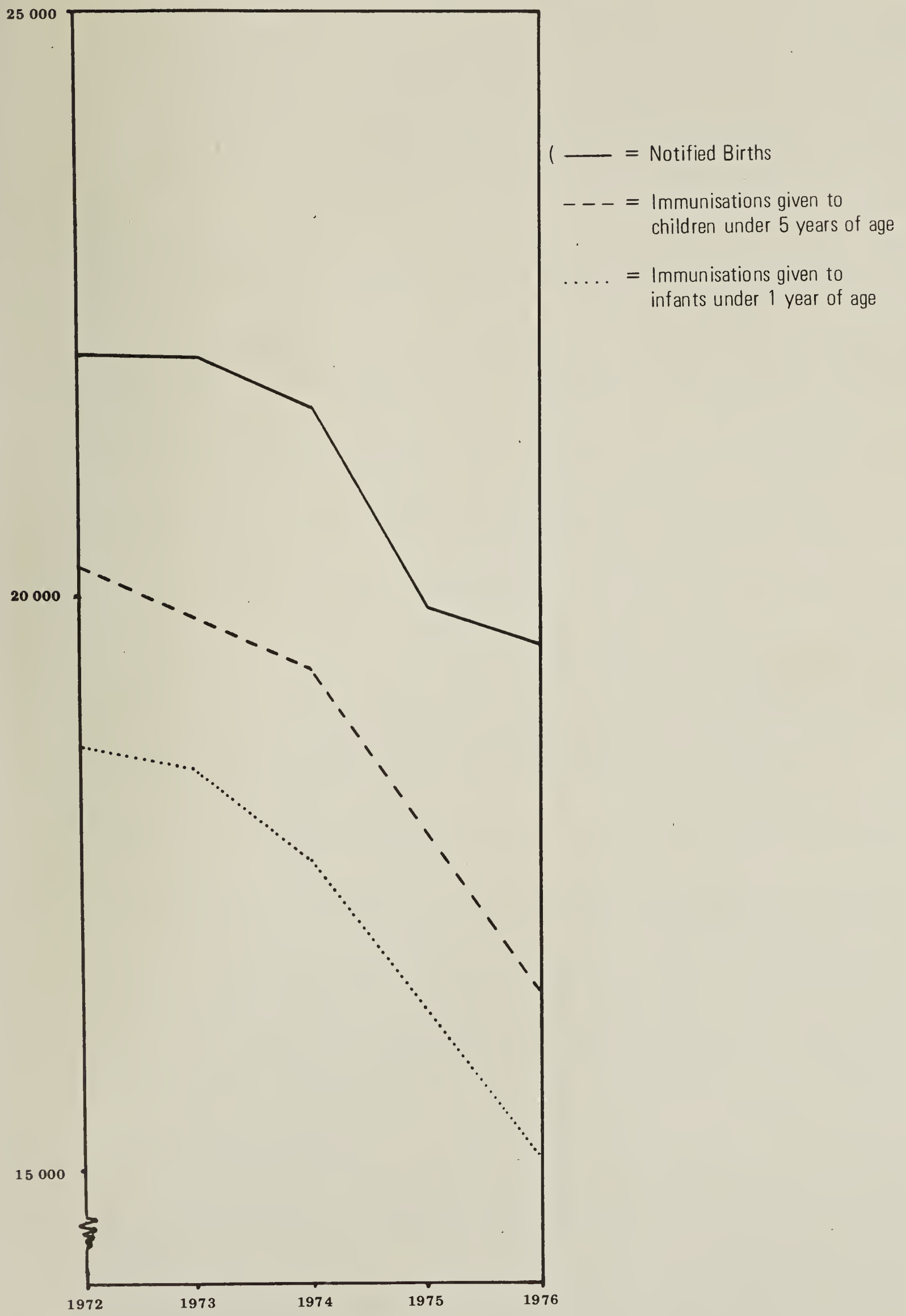
Despite all efforts to secure completion of the course there is a clear fall-off in attendances for 2nd and 3rd doses as compared with 1st doses administered. This necessitates much home visiting by the Public Health Nurses to persuade defaulting parents to bring their children to the clinic.

In perusing these statistics it should be remembered that of the Notified live births many were dead or ill



Child Welfare Clinic in progress

Figure 4.3: *THE NUMBER OF COMPLETE TRIPLE DOSE POLIOMYELITIS IMMUNISATIONS ADMINISTERED IN RELATION TO THE NUMBER OF NOTIFIED BIRTHS: 1972 – 1976*



before reaching the age of one year – in 1976 there were 740 such deaths alone (equivalent ot 3,7%o of the total Notified births) of which 707 were Black, Coloured or Asian and 33 were White. In turn, of the 707 Black, Coloured or Asian deaths, 375 were aged less than three months so that the real penetration of the immunising service was even better than the crude percentages would indicate.

c) Smallpox

Vaccination was made compulsory by Govt. Gazette No. R 2197 of 1930–12–05. During 1976 11 334 persons (1 723 White and 9 611 Coloured, Black or Asian) were vaccinated at child welfare centres.

21 972 Black adults were vaccinated at Langa by the Health Inspectors.

d) Tuberculosis

B C G immunisation was made compulsory by Government Gazette No. R 1754 of 1973–09–28; except where the parent or guardian objects in writing, this must be commenced (i.e. given for the first time) within six months of birth.

Japanese Freeze dried B C G is supplied by the State Health Department; in previous years an unsatisfactory vaccine had been used and thus there has been need to reimmunise school entrants for the past few years.

34 682 B C G vaccinations were given during 1976 – 20 557 to infants and pre-school children (3 125 White and 17 432 Black, Coloured or Asian) and 14 125 to school age children (57 White and 14 068 Black, Coloured or Asian).

B C G is administered percutaneously via 40 punctures to infants aged three months as a routine and also to Tuberculosis contacts who were tuberculin negative (see page 61).

e) Measles

A measles immunisation programme was begun in February 1974. Nearly 11 000 doses were administered to children in 1974, 10 100 in 1975 and 11 469 in 1976.

Infant and Toddler Nutrition

Information on this subject is given to mothers at Child Welfare clinics. Breast feeding is encouraged, and instruction is combined with test feeds when necessary.

Where supplementary dried milk feeding is necessary, milk for this purpose is supplied at prices ranging from cost down to nothing depending on the financial circumstances of the mother.

During the year 42 954 Kg of dried milk fortified with Vitimin D and supplemented with iron were sold at cost.

The pilot scheme started by the State Health Department in 1961 for the distribution of dried skim milk to necessitous toddler groups for the prevention of Kwashiorkor has been continued on a permanent basis. The City Health Department obtains the milk and distributes it; and in 1976 an amount of 49 950 Kg was distributed to over 1 900 children on a weekly basis with the parent contributing as much of the City Councils share of the cost as possible.

4 365 Kg of skim milk powder provided by the Council were supplied to children at Council creches and Nursery Schools.

Without these schemes the state of infant nutrition in many cases would be parlous indeed.

Nursery Schools and Creches

This Department is involved in both the operating of a number of creches/nursery schools and in the inspection of private creches/nursery schools with a view to determining the suitability or otherwise of applications to licence or register such enterprises.

Municipal Creches/Nursery Schools

The activities of these institutions are controlled by the Nursery School Supervisor and are detailed in Table IV.X.

The Guguletu III creche was razed by fire in August 1976 and that at Manenberg, which was only opened as recently as February 1976, was severely damaged by fire in September 1976 during the period of civil unrest.

The function of these municipal day care centres is to provide necessitous families and particularly families where a breadwinner may be smitten with illness e.g. T B etc., with the opportunity for the mother to add to family income by working while at the same time providing a healthy psychological, social, physical and educational environment for the underprivileged child.

Private Creches/Nursery Schools

Persons wishing to establish creches or creches – cum Nursery Schools (premises caring for more than six children of pre-school age even if only for part of a day or on a few days a week) must:–

a) Apply for a trading licence (in terms of the Registration and Licensing of Businesses Ordinance) from the Town Clerk. The Health Inspectorate reports on the suitability of the premises from a Public Health point of view.

b) Register with either the Department of Social Welfare and Pensions (Whites), Coloured Affairs (Coloured), Bantu Administration (Black) or the Department of Indian Affairs (Asian).

Standard requirements of this Department are available on request.

Regular inspections of existing premises are made to ensure Health standards are maintained.

School Eye Clinics

An ophthalmologist, assisted by a Public Health Nurse and Clinic Nurse, was present at 268 ophthalmic sessions for school children held during 1976 and which resulted in 1 741 children receiving spectacles (Attendances are detailed in Tables IV.VI and IV.XI). New cases numbered 31^{0}/o fewer than in 1975 as did total attendances although the number of spectacles fitted was only down by 26^{0}/o.

Protected infants and other Social Welfare work.

a) Protected infants

Children under the age of seven years living with foster parents must be registered with the Commissioner of Child Welfare of the district. He is empowered to nominate infant protection visitors to visit the foster home and make reports thereon – the Public Health Nurses of this Department have been so nominated and in 1976 were responsible for visiting 30 protected infants in the Cape Town and 57 in the Wynberg Magisterial districts.

Reports on these children must cover all psychological, social and physical aspects of the foster care being provided and, if they are adverse, these reports may result in the removal of the child to the care of a more suitable person.

b) Other Social Welfare Work

A Social Worker is employed by the Department to assist the Public Health Nurses in this aspect of their work and to this end she visits the clinics on a regular basis and is available for interviews in between these visits.

Much work is done amongst unmarried mothers and their children, especially where the mother is aged 16 years or less (in 1976 there were 35 White, 266 Coloured or Asian and 134 Black mothers in this category).

A total of 5 097 visits and 34 interviews (covering both non-institutionalised individuals and persons in

institutions or hospitals) were conducted during 1976 which represents an increase in the Social Workers workload of 26%/o over 1975.

Close liaison is maintained with welfare organisations including the Society for the Protection of Child Life, the Afrikaanse Christelike Vrouens Vereniging, the Christelike Maatskaplike Raad and various State Departments.

TRAINING PROGRAMMES

The training of health personnel is of paramount importance for the proper development of promotive and preventive health services as a community asset. While the conceptual education function of courses and seminars have a significant influence in the training function, in-service training within the Department itself is of material importance in the development and training of community health personnel.

During the year under review the Department provided in-service training for medical students and student nurses, as well as student midwives, from seven training hospitals in the municipal area. In addition, continuous in-service training in preventive and promotive personal health services was provided for the Department's own staff of Public Health Nurses, Clinic Sisters and Clinic Assistants.

Where requested by Colleges for Advanced Technical Education, practical training of students from outside the Service was undertaken by my Department during the student's vacation periods.

Formally structured training was provided for medical members of the staff undertaking post-graduate courses in Community Medicine, and also for training courses leading to the Diplomas in Public Health, Public Health Nursing, the Certificate in Nursery School Teaching, Nursing Assistants and Enrolled Nurses.

The main details of the training of health personnel in 1976 are as follows:—

Structured Training Courses

Course	Medical Post-Graduate Diploma in Community Medicine	Health Inspection Diploma in Public Health	Community Health Diploma in Public Health Nursing	Teaching Certificate in Nursery School Teaching	Nursing Enrolment as Nursing Assistant and Staff Nurse	Family Planning Family Planning Certificate
Students	2	3	7	4	3	5

In-Servcie Training

Course	Medical Post-Graduate Diploma in Community Medicine	Nursing Preventive and Promotive Community Health Services	4th Year Medical Students U C T	Final Year Medical Students U C T	Induction	Senior Induction	Supervisor's (Admin)
Internal Students		166			10	3	4
External Students	4	117	156	150			

GERIATRIC SERVICE

Since 1975 there has been a renewed awareness amongst the medical profession all over South Africa of the plight of the aged in the community. With the world trend being away from homes for the aged, it became necessary to keep the elderly healthy and happy in the familiar surroundings of the communities in which they lived. It has been conclusively shown that most of the afflictions of the aged were reversible and preventable and that morbidity could be drastically reduced if these afflictions were diagnosed and treated at an early stage.

Geriatric patients being transported for a dental check-up

Cogniscant of its responsibilities towards the senior citizens of the City of Cape Town in the field of prevention, the Health Department, in 1975, set out to establish a geriatric screening service as an integral part of a comprehensive preventive and promotive health service at the first Community Health Centre at Heideveld township. Community Health Nurses, assisted by other nurses and Health Inspectors conducted a house to house survey of all persons over the age of 60, taking their names and addresses and noting any major physical, mental or social handicaps. The data obtained from this survey was analysed and later published in the South African Medical Journal.
(T.F. NEWMAN, S. Afr. Med. J., **51**, 427 (1977)).

Thus the need for a Geriatric Screening Clinic was firmly established and on 1975–08–06 the first such clinic was held at Heideveld.

A fixed pattern for the running of the clinic was formulated. The Community Health Nurse, having obtained the names and addresses from the survey, would visit eight to ten persons in her area every week and invite and motivate them to attend the clinic and at the same time obtain a detailed personal, medical and socio-economic history which was recorded on a specially designed Geriatric Card.

On the day of the clinic the same Health Visitor would fetch them at their homes and bring them to the clinic in transport provided by the Health Department. At the clinic the individual is given a complete medical examination by the Medical Officer who also takes cognisance of any social, economic and environmental problems. Again all the findings, including the result of a routine chest X-Ray, are recorded on the Geriatric Card.

It was found that most old persons suffered from more than one condition which could be easily treated at a General Hospital or at a Day Hospital – and they were therefore given letters of referral to these hospitals.

At the end of each clinic the patients were taken home by the Health Visitor. Subsequent home visits would ensure that all referrals were followed through and should any new problem arise, the patient could be brought back to the clinic in the same way.

Similar clinics were started at Silvertown on 1976–08–03, at Retreat on 1976–11–05, each being preceded by a house to house survey. These clinics proved highly successful and were readily accepted by the residents of these areas and have become one of the most popular components of the health service. Attendances during the year are detailed in Table IV.XII.

Community Involvement

In each area a survey was also made of all churches, old age clubs and welfare organizations. These were invited to form a "VOLUNTARY WORKERS' COMMITTEE FOR THE ELDERLY" at each Community Health Centre.

Members of these Committees take turns in providing refreshments for the elderly at each clinic session. They also assist with home visiting and home help for deserving cases and provide escorts for some who have to attend various hospitals. The greatest contribution of these Committees, however, is in the provision of a chiropody service for the elderly, which for various reasons could not as yet be financed by the City Council. Through donations, cake and rummage sales these Committees hope to provide this most essential and most welcome service until the City Council is able to appoint a chiropodist.

Future Development

A house to house survey is currently in progress at Kensington, and similar surveys and clinics are planned for the Community Health Centres at Bonteheuwel, Netreg, Manenberg, Hanover Park, Parkwood, Wynberg and Mitchells Plain and in other areas where the need can be established.

DOMICILIARY VISITING

While a great deal of important work is performed at the clinics by the Public Health Nurses their really vital task is to visit persons needing advice and assistance in their homes. Concurrently with the conversion of services to comprehensive polyclinic concept is a change in clinic records to the form of Family Folders. This means that a public health nurse visiting a home has at her disposal in one folder records relating to all

members of this family.

Home visiting enables the Public Health Nurse to guide mothers in the care of their children in relation to the home. Routine visits should be made soon after the infants birth and at least every three months thereafter during the first years of life. However, staff shortages often interfere with this ideal, especially as home visiting is also essential for other reasons such as for cases of notifiable or other infectious diseases; where there are socio-economic or other domestic problems; where some family member has defaulted on a clinic appointment for a variety of services; ante-natal and geriatric visiting.

The different visits made by Public Health Nurses are given in Table IV.XIV. There were significant percentage **increases** in the number of visits made for the following reasons (over the 1975 figures given in brackets):– Gastro-enteritis up by 62^{0}/o (over 186); geriatrics up by 193^{0}/o (over 3 048); routine house to house visits up by 45^{0}/o (over 20 332); protected infants up by 10^{0}/o (over 1 120); venereal disease visits up by 104^{0}/o (over 480).

There were significant percentage **decreases** in the number of visits made for the following reasons (over the 1975 figures given in brackets):– Ante-natal cases down by 12^{0}/o (over 1 287); Immunisation failures down by 13^{0}/o (over 4 081); Infectious diseases (other than gastro-enteritis, Tuberculosis or V D) down by 20^{0}/o (254); Midwife visits down by 58^{0}/o (over 1 105); Tuberculosis new case visits down by 7^{0}/o (over 3 304); Tuberculosis follow-up visits down by 32^{0}/o (over 38 792).

Because of changes in data presentation it is not possible to demonstrate changes in 'new birth', 'subsequent neonatal' or 'other' visits except to say that taking these together there was a decrease of 8^{0}/o (over 106 605) to 98 118.

Total home visits decreased by 3,5^{0}/o (over 181 648) to 175 218.

HEALTH EDUCATION

Every contact with the public presents a potential teaching situation and it is for this reason that **all members** of the health team should be trained and motivated for the important task of health education of the public.

Emphasis was again placed on in-service training of professional staff in principles and methods of health education, and training courses were held for public health nurses and dental nursing staff throughout the year.

In-Service Training of Staff

The in-service training sessions conducted during the year and attendance thereat during 1976 was as follows:–

NO. OF LECTURES	NO. OF ATTENDANTS	STAFF DESIGNATIONS
24	48	Public Health Nurses (Child Welfare)
6	11	Public Health Nurses (Tuberculosis Branch)
6	18	Bantu Public Health Nurses
5	10	Dental Nursing Staff

At the conclusion of the course of lectures and demonstrations, the staff demonstrated projects in the form of flannelgraphs which they had themselves produced. The flannelgraphs and their presentation were of a high standard and subjects covered included nutrition, control of obesity, family planning, accident prevention and the control of Tuberculosis.

Certificates were awarded by the Department to those staff members who had successfully completed the course.

The vacant post of Bantu Health Education Lecturer was filled in January. After undergoing intensive in-service training in all aspects of health education and the use of visual aids, the present incumbent, who was formerly a school teacher, has been actively assisting with health talks and demonstrations in the Bantu Townships of Langa and Guguletu.

Food Handlers

By arrangement with the managements of Messrs Checkers and Woolworths, a comprehensive series of lectures, film shows and demonstrations on the hygienic preparation and handling of foodstuffs was arranged for all food handlers employed by these firms.

Following on the lectures at which over 1 500 employees attended, the management of these firms have commented favourably that they have noted a marked awareness of the importance of hygiene amongst their food handling staff.

Clinics and Community Health Centres

As in the past, regular health talks, film shows and flannelgraph demonstrations were given throughout the year at all major Child Welfare and Tuberculosis Clinics.

The lectures, which were given by the health education staff, clinic sisters and public health nurses to large audiences, covered such subjects as infant care and feeding, bottle hygiene, nutrition, family planning and the prevention of accidents in the home.

Schools

Many requests were again received for health education talks and film shows at various schools in the Peninsula and these talks were enthusiastically received by both staff and pupils alike.

Subjects which proved most popular at the schools were the dangers of smoking and the activities of the Public Health Department which were illustrated by a set of slides produced by the Department.

Family Planning

Advice and assistance on health education methods and techniques, including the operation of film projectors, was rendered for the newly appointed Family Planning Liaison Officer and her Coloured Family Planning Field Workers. A film projector and daylight screen has been loaned to this section for the screening of family planning films.

Hospitals

The Health Education Branch again worked in close liaison with the Day Hospital Organisation, and lectures and film shows were given throughout the year at Day Hospitals in the Coloured areas and Bantu Townships of Langa and Guguletu.

At Heideveld Day Hospital, the health education branch assisted with health education seminars for children attending the Sunshine Club, which was formed to promote health education with local indigent children.

Health education talks and film shows were also given for patients at the Peninsula Maternity Hospital and the Brooklyn Chest Hospital.

Health Education in Bantu Affairs Administration Board areas

Despite the civil unrest during the year, regular health education talks, film shows and demonstrations were given by the Health Lecturer.

The lectures were given for large groups of Black patients attending at the Langa and Guguletu child welfare and Tuberculosis clinics and at the Day Hospitals and vaccination centre.

General

Nico Malan Nurses Training College – Two lectures on principles and methods of health education were

given for 65 student nurses.

Hewat Teachers Training College – An illustrated talk on veneral disease was given for a large group of student teachers.

Cape College for Advanced Technical Education – Assistance was rendered to the College with lectures on principles and methods of health education and the construction and use of visual aids for the student public health nurses; and also assessment of projects and talks given by the nurses.

A set of 35mm slides on child growth and development was produced for use by the College.

University of Cape Town – Health education seminars were arranged for four doctors studying for the diploma in community medicine.

Ward 16 Ratepayers Association – By arrangement with Councillor Steyl, two evening talks on the work of the City Health Department were given for local ratepayers.

Sea Point Girl Guides Association – An illustrated talk on Bilharzia was given for Peninsula guide leaders.

Public Health Inspectors Association – Slides were screended for Professor C J du Toit of Stellenbosch University in support of a talk which he gave to the Association on auditory problems.

The photographs and slides required for exhibition purposes and for inclusion in the annual report were taken by the Health Education Branch.

The statistics in Table IV.XIII reflect the health education lectures given by the health education and nursing staff during the year. They do not include health educational advice and assistance given to individuals by doctors, nursing staff and health inspectors, which aspect also constitutes and important facet of the health education services of the department.

Audience viewing Health Education film

SECTION V

TUBERCULOSIS (TB)

Tuberculosis remains the greatest single communicable disease problem in Cape Town; it affects mainly the underprivileged and, despite major efforts at control, will remain a problem so long as sections of the Cape Town population remain exposed to infection and to the effects of malnutrition, overcrowding, ignorance, cultural apathy and general socio-economic deprivation.

As well as the cost to the patient and his family, both financially and in terms of personal suffering, the costs of the failure to prevent tuberculosis weigh heavily upon tax and ratepayers and justify continually growing expenditure on preventive measures.

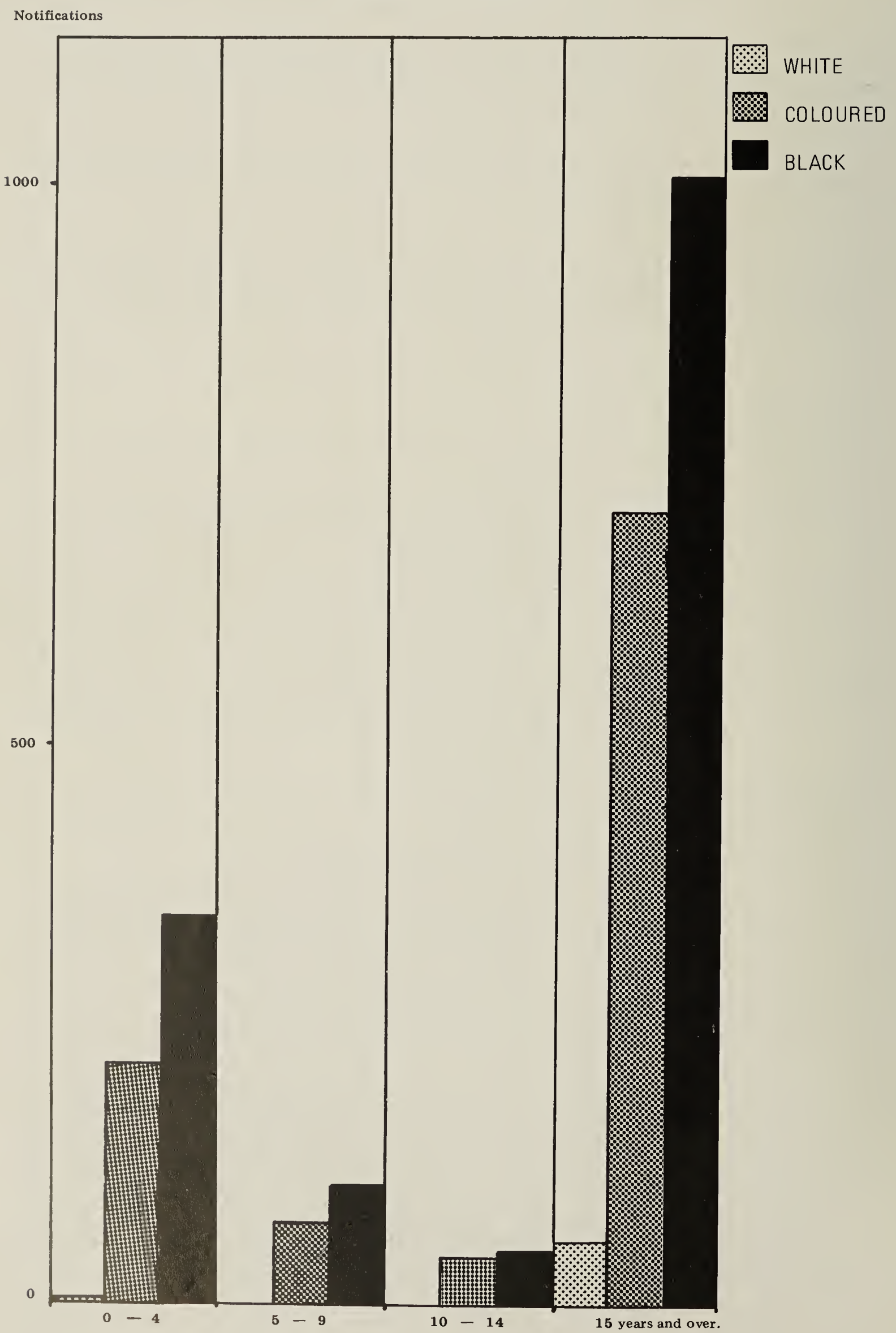
The amount of ill health due to tuberculosis in Cape Town is gauged by means of the Notification of cases of the disease under the Public Health Act and is discussed below in terms of Morbidity data. Other sub-sections dealing with Mortality due to Tuberculosis and with Prevention follow. Various definitions of the terms used in this Section are given in the box below.

DEFINITIONS

"Incidence of Tuberculosis"	–	the number of Notifications recieved per year per 1 000 of the population.
"Prevalence of Tuberculosis"	–	the number of Notified cases still requiring treatment as at 1976–06–30 per 10 000 of the population (Note : irrespective of when they were Notified).
"Local cases"	–	persons resident in the Municipal area of Cape Town for at least six months prior to Notification as TB cases.
"Imported cases"	–	persons resident in the Municipal area of Cape Town for less than six months prior to Notification as TB cases.
"Out of City cases"	–	persons not resident in the Municipal area of Cape Town at all but whose tubercular illness was made known to the City Health Department because of local diagnosis of the condition or because of the entry of such patients to the Municipal area for purposes of treatment.
"Municipal area of Cape Town"	–	includes the Bantu Affairs Administration Board area of Langa and Guguletu.
"Pulmonary Tuberculosis"	–	(a) In previous years this has included only tuberculosis obviously affecting the lungs and pleura. (b) As from 1976 the term is used to describe tuberculosis of the lower respiratory tract, pleura and pulmonary lymphatic drainage system as well as recent tuberculin convertors such as tuberculin positive reactors under the age of five years who have not had B C G.
"Other forms of Tuberculosis"	–	means all forms other than pulmonary.

In discussing the problem of pulmonary tuberculosis as distinct from other forms of the disease it is necessary to refer to all cases infected via, and with the potential to spread the disease by, the pulmonary route. As is noted in the definitions this means that cases Notified on the basis of having 'Mediastinal glandular enlargement on x-ray' must be included as Pulmonary cases; this has not been so in previous years when such cases were classified as 'other forms – glands'. In the local situation, where bovine tuberculosis is extremely rare, recent conversion to a state of tuberculin positivity is indicative of infection via the pulmonary route (unless the person in fact has been given B C G) and thus cognisance must be taken of tuberculin positive reactors under the age of five years who have not had B C G, when describing the problem of pulmonary tuberculosis; such cases are included in the pulmonary tuberculosis group for 1976 but were not so included in previous years. As a result of these changes in what is classified as pulmonary tuberculosis it is clear that great care must be exercised in comparing figures relating thereto for 1976 and previous years.

Figure 5.1 *LOCAL AND IMPORTED NOTIFICATIONS OF TUBERCULOSIS (ALL FORMS) BY RACE AND AGE-GROUP: 1976*



MORBIDITY DUE TO TUBERCULOSIS

The amount of ill health due to Tuberculosis is gauged by study of the Notifications thereof made under the Public Health Act. The sheer number of such Notifications indicates the sum total of individual suffering and the load placed on health resources; the incidence and prevalence rates usually reflect the similarities or differences in the occurrence of tuberculosis in different population groups or in the same group over different time periods (although it may reflect the case-finding ability of the health service and changed criteria may make comparisons difficult). The importance of Notification cannot be overemphasised but the validity of data based thereon is nevertheless somewhat impaired by under-reporting and incidence rates based thereon do not indicate the number of new cases by time of onset of infection or disease but only by time of diagnosis thereof.

ALL FORMS OF TUBERCULOSIS

Notifications received during the year (Table V.I) showed a decrease for Local cases from 2 177 in 1975 to 2 013 in 1976 although Imported cases rose from 456 to 622. There were also 55 cases hospitalised from out of City areas in 1976 compared with 124 in 1975.

Age distribution of Notified cases is shown for 1976 (Local and Imported cases) in Table V.XX and Figure 5.1. While 87^{0}/o of White, 69^{0}/o of Coloured, 67^{0}/o of Black, and both Asian cases were adults (15 years or more), the age distribution under 15 years showed the classical preponderance of cases in the under five years age group. Black and Coloured Notifications are illustrated by year of age of the patient in Figure 5.2 which shows peaks for the former at 2 years and the latter at one year of age.

As demographic data is incomplete, age- specific incidence rates cannot be estimated for Blacks but using the data in Tables V.IV and V.XX as in Table V.XXII such rates for Whites and Coloureds can be gauged. The lowest incidence rates of Tuberculosis (all forms) per 10 000 population were (at 7,6 for Coloured and 0 for White) in the 10 to 14 year age group. The highest such rates were in the 0 to 4 year age group (30,1 for Coloured and 3,4 for White).

Race distribution of Notified cases is shown for 1976 (Local and Imported cases) in Table V.I. There were 1 521 Black (57,7^{0}/o), 1 047 Coloured (39,7^{0}/o), 65 White (2,5^{0}/o) and 2 Asian (0,1^{0}/o) cases.

Incidence rates per 1 000 population are given for 1972 to 1976 (Local cases only) in Table V.IV by race. In Whites the incidence of 0,22/1 000 population was the same as the five year average. In Coloureds the rate of 2,01 was slightly lower than the five year average of 2,05. The Asian rate of 0,09 was much lower than the average of 0,35 while the Black rate of 10,02 was slightly lower than the average of 10,33 over five years.

Prevalence of Tuberculosis (all forms). The number of Notified cases of Tuberculosis (Local and Imported) still requiring chemotherapy has been roughly estimated by assuming an average period of treatment of 18 months, discounting any deaths due to the disease and calculating the prevalence rate per 10 000 population from the total Notifications received in 1975 and half those received in 1976 (see Table V.XXI).

There were, as at 1976–06–30, 7,2 Asian; 3,8 White; 33,9 Coloured and 232,4 Black Local and Imported Notified cases of Tuberculosis (all forms) still requiring chemotherapy (whether infective or not) per 10 000 of each population group. There was one such case for every 43 Black, 295 Coloured, 1 389 Asian and 2 632 White residents.

Discounting race there was a prevalence of 48,2 cases per 10 000 population or one such case for every 207 Municipal residents.

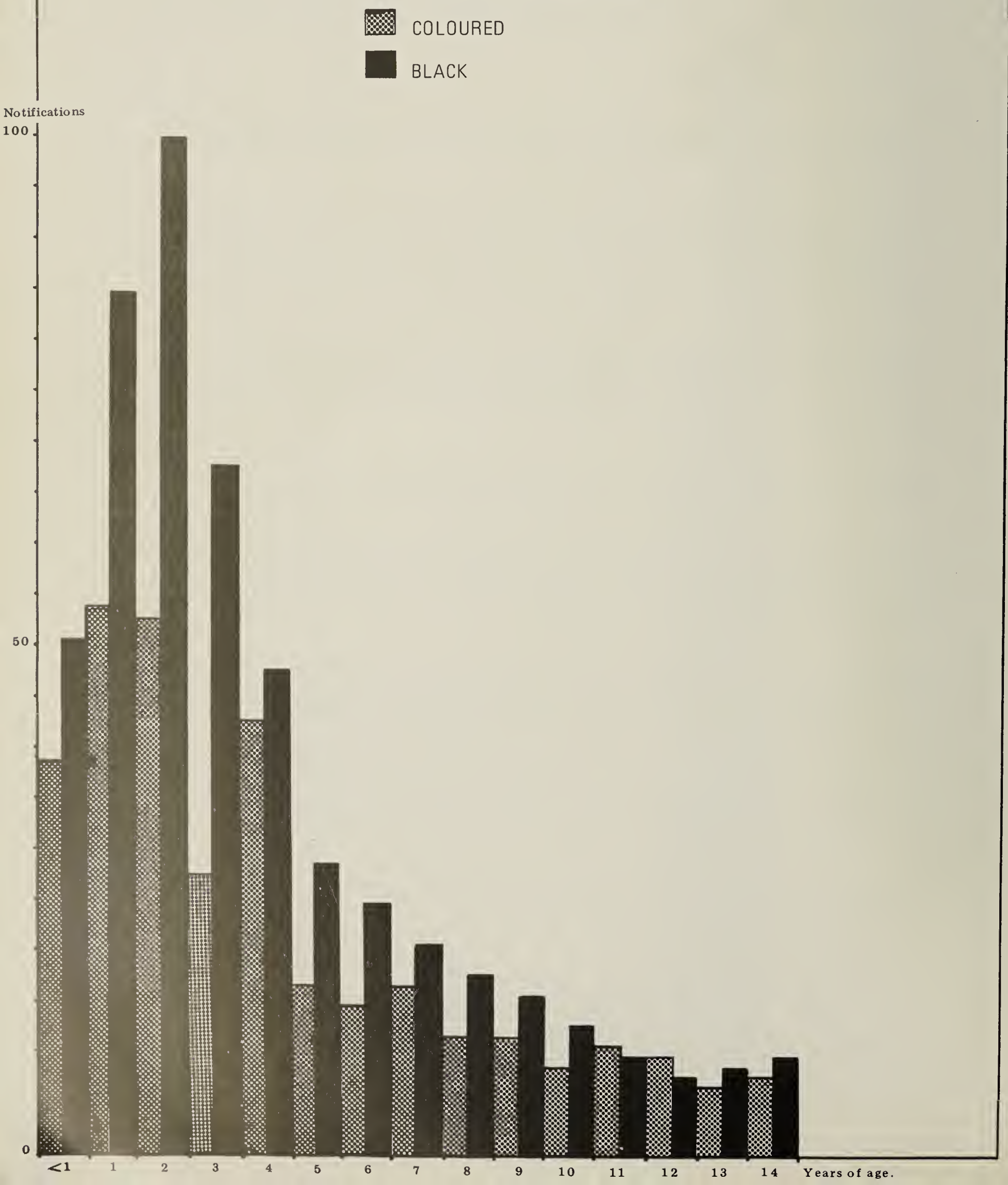
PULMONARY TUBERCULOSIS

Despite the generally lower number of Local notifications given above, the number of Pulmonary forms notified apparently rose from 1 685 in 1975 to 1 972 in 1976. This was for reasons discussed on page 59.

The apparent increase in the Notification rate in 1976 (most marked in Blacks) over 1975 as detailed in Table V.IV is due to the changed criteria discussed.

The differences between race groups remained striking i.e. there were for Asians 0,09; Whites 0,21;

Figure 5.2 *AGE AT NOTIFICATION OF ALL FORMS OF TUBERCULOSIS IN COLOURED AND BLACK CHILDREN UNDER 15 YEARS OF AGE; LOCAL AND IMPORTED CASES: 1976*



Coloured 1,94 and for Blacks 9.87 Notifications of Pulmonary Tuberculosis per 1 000 population in 1976.

OTHER FORMS

There was an apparent sharp decrease in the number of such notifications for reasons mentioned above (i.e. in 1975 there were 421 cases classified as 'Glands' whereas in 1976 there were only 4 such cases because in the latter year only cervical glands were so classified and mediastinal glands were grouped in the pulmonary section). Details of the forms involved are given in Table V.III.

Notification rates are detailed for 1976 and the previous four years in Table V.IV.

Tuberculosis Meningitis (TBM)

A decreased incidence of this condition is said to be one of the major benefits of BCG immunisation and to reflect adequate control measures against Tuberculosis. As will be seen from Figure 5.3 the fall in incidence rates per 100 000 population since 1960 for whites has been dramatic. In Coloureds the progress made by 1974 has not been continued, which calls for further investigation. In Blacks the disease has not been controlled at all but the main reasons (high exposure to infection, very poor socio-economic circumstances and logistic difficulties in tracking down new births when the mothers are often 'illegally' present) are not easy to tackle.

MORTALITY DUE TO TUBERCULOSIS

In general Mortality due to tuberculosis remained low but it remains a major cause of death in Blacks and to a lesser extent in Coloureds. (See Figures 3.7 and 3.8). The death rates quoted below are the number of deaths due to tuberculosis registered during 1976 per 1 000 of the population indicated. The **Mortality** of Tuberculosis does not reflect the fate of new cases in any year but rather the terminal stage of infections which could have occurred at any time in the past. It thus reflects past, as well as current, failure to prevent, treat and cure.

ALL FORMS

The death rates due to all forms of tuberculosis combined are summarised in Table V.VII which shows a slow and steady fall in the death rate for the population as a whole.

PULMONARY TUBERCULOSIS

The numbers of deaths and death rates are detailed in Table V.V for 1976 and the preceding year. While the number of deaths remained small in Whites it was four times that in 1975 (4 as against 1 death). Coloured deaths decreased from 80 to 71; Black from 76 to 75; and there were no Asian deaths.

The death rate due to Pulmonary Tuberculosis has dropped slowly but steadily over the past few years as can be seen from Table V.VI. Taking the White figure as unity the relative magnitudes of the death rates due to Pulmonary Tuberculosis in 1976 are 0:1:7 1/2:37 1/2: for Asians:Whites: Coloureds:Black.

OTHER FORMS OF TUBERCULOSIS

The numbers of deaths due to various forms of tuberculosis other than PTB are detailed in Table V.III for 1976 – it will be seen that tuberculosis meningitis is the only other significant cause of death and the numbers of deaths and death rates due to this deaths are detailed in Table V.XXIII for 1960 to 1976. The 1976 Death rate of 1,02/100 000 for Coloureds (including Asians) was close to the ten year average of 1,3 (1967 to 1976). In Whites there were no deaths and in Blacks the 1976 figure of 5,97 was close to the ten year average of 5.87.

Deaths due to TB other than PTB but including TBM are given for 1972 to 1976 in Table V.VI and do not show either an upward or downward trend.

PREVENTION OF TUBERCULOSIS IN CAPE TOWN

PRIMARY PREVENTION

Nutrition education and general health education regarding the disease are important general measures

Figure: 5.3 *NOTIFICATION RATES PER 100 000 POPULATION OF TUBERCULOUS MENINGITIS, BY RACE, 1960 – 1976*

———— BLACK

..... COLOURED (Includes Asians)

– – – – – – – – – WHITE

taken. The infectious pool is continually being renewed by the migrant labour force entering Cape Town from the Homelands and without the abolition of the migrant labour system it is difficult ot envisage how this situation can be improved. Until the socio-economic status of the depressed classes of Cape Town society is improved, particularly in respect of housing and nutrition, concerned health officials must continue to strive to secure such relief.

Specific protection of up to 80^{0}/o of previously unexposed persons can be obtained by means of immunisation with B C G vaccine (Bacille Calmette – Guérain) and this is offered free in terms of the compulsory regulations mentioned on page 48 . In 1976, 14 125 school children and 20 557 pre-school children were given such protection as part of the mass immunisation programme. A further 3 427 tuberculin negative contacts of Tuberculosis cases were protected with B C G vaccine during 1976, compared with 2 997 the previous year.

SECONDARY PREVENTION

Diagnosis

Efforts to diagnose cases of tuberculosis as early as possible are directed mainly at those groups in the community most likely to be affected, namely those who have been in contact with known cases and those who have suspicious symptons. In addition mass screening for tuberculosis is performed.

Suspects are referred to the City Health Department by many different health services, private and public. In 1976 of the total of 2 690 local and imported Notified cases, 267 were Notified by private practitioners, 1 326 were Notified by general hospitals and other institutions; other local authorities Notified 53 and the City Health Department Notified 1 044 (many of whom had been referred to clinics as suspects).

The fate of persons attending City Council clinics as suspects is detailed in Table V.VIII 25^{0}/o of all such suspects were Notified after investigation.

Contacts comprise the most important high risk group to be investigated and in 1976 there were 3 747 such contacts investigated at City Council clinics of whom 8,5^{0}/o were later Notified as cases of Tuberculosis. Only 1,5^{0}/o of White contacts were later Notified, compared with 9,01^{0}/o of contacts of other races. Staff in contact with cases of active tuberculosis are subject to regular routine screening.

Mass x-ray screening facilities continued to be offered at the Chapel Street Clinics as a free service to Municipal residents and at Langa as a free pre-employment screening service operated on behalf of the Bantu Affairs Administration Board. The work done at Chapel Street is summarised in Tables V.X and V.XI and at Langa in Table V.XII.

Out of a total of 63 624 examinations at Chapel Street, 167 cases of active pulmonary Tuberculosis were discovered, however 34 were previously known which leaves a 'new case' discovery rate of 133/63 624 examinations or 0,2^{0}/o. These Notifications however amounted for 4,9^{0}/o of all (local and imported) notifications received during the year.

At the Langa Mass X-Ray unit the number of examinations was much below that of previous years because the building was fired during the civil unrest and no x-rays taken here from July until the end of the year. Of the 16 622 X-Rays taken, 140 (0,84^{0}/o) revealed new cases of Tuberculosis. This figure contributed 5,2^{0}/o of the total (local and imported) Notifications received during the year.

Although the case-finding yield per hundred thousand x-rays is relatively small, it must be emphasized **that a large proportion (over 10^{0}/o) of all notified cases are discovered by this means.**

Treatment

Hospitalisation has many theoretical advantages but in practice many of these are not in the best interest of either the patient or the community. Admission is usually restricted to cases where the patient:–

(a) Has moderately severe symptomatology (high fever, severe weight loss and weakness, haemoptysis) which require a period of bed rest, provided that the patient himself agrees that he feels the need for rest.

(b) Has an associated condition which would be better treated in a hospital, especially if this constitutes an adverse aetiological factor in the causation of Tuberculosis.

(c) Has no source of income, no family or friends to care for him and/or no roof to sleep under. Steps to correct such a state of affairs must be set in motion at once (see TERTIARY PREVENTION and social aid below).

(d) Is sputum positive and by virtue of occupation or domicile (e g resident master at school, nursemaid living-in etc) would otherwise be placed in close contact with susceptible persons. (This does not apply to persons diagnosed as being sputum positive who continue to live in accommodation occupied by friends or family who have in any event been exposed to infection up until the time of diagnosis).

Patients are admitted to the City Hospital (see Chapter VIII) or the Brooklyn Chest Hospital. Every possible step to retain the patient as a functioning member of society needs to be taken and it will be seen from Table V.XIII that in 1976 of the 1,972 local residents notified as having pulmonary tuberculosis only 797 (40%) were admitted to hospitals for commencement of therapy. Of the 614 Notified persons resident here for less than six months, only 235 (38%) were so admitted. Out-patient therapy was offered to the remainder with the advantages to an individual patient of being able to continue working, remain with the family, not having to put up with the boredom of institutional life and remaining much more a master of his own destiny.

Considerable support is needed from the clinic staff to ensure that continuation of therapy is made as simple, easy and pleasant as possible for the patient.

During 1976 out-patient clinics were held at ten different centres (see Table V.XIV which details new consultations and total attendances thereat) and despite the disruption to Services occasioned by the civil unrest the number of new consultations at the clinics was, at 11 927, only 27 lower than the previous year, while the total attendances were some 8%/o lower at 72 364 compared with 78 895.

The total attendances at Langa and Guguletu fell by 29%/o to 19 105 in 1976 form 26 961 in 1975 but most of the Black patients were attended to at the central city clinic at Chapel Street where attendances rose by 25%/o in 1976 over 1975 (from 11 482 to 14 342).

Attendances at most of those centres offering the new Comprehensive Health Centre services rose e.g. Lavender Hill offered TB clinics for the first time and had 265 new attendances and 1 373 total attendances; Heideveld total attendances rose by 21%/o; Retreat total attendances rose by 4 1/2%/o, attendances fell slightly at Silvertown however, from 12 451 to 12 077 (–3%/o).

The total number of sessions held (see Table V.XIV) declined slightly from 1 204 in 1975 to 1 163 in 1976 (–3,4%/o). The average number of persons attending per session was 65,5 in 1975 and 62,2 in 1976.

The spectrum of cases attending for the first time is detailed in Table V.VIII.

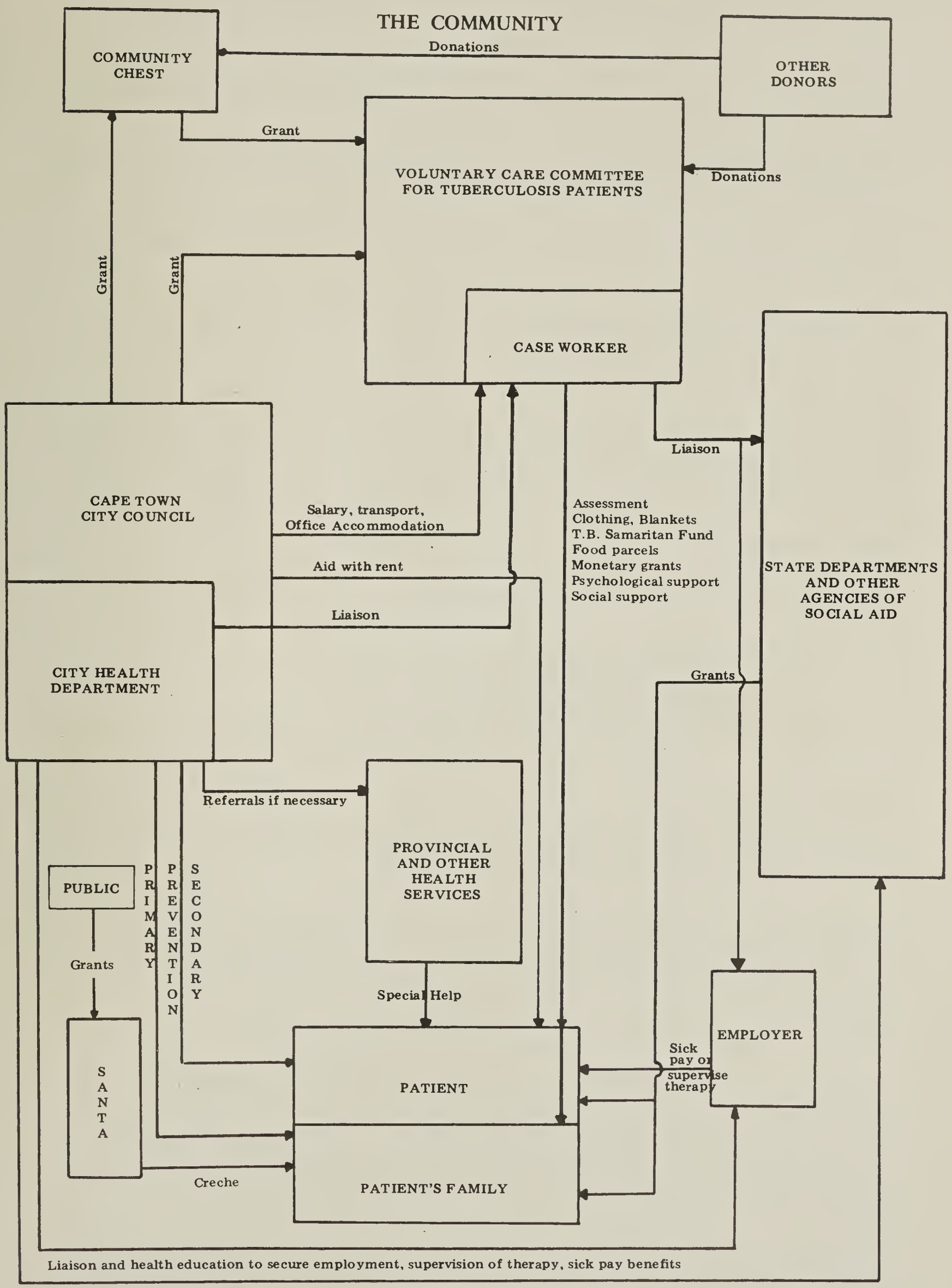
The place of care of all the new notifications made in 1976 and the reasons why any did not attend the clinics, are detailed in Table V.XVI.

In respect of local cases:–
It was disturbing to note the large number of persons who were dead on notification – 71 as compared with 52 in 1975, 15 in 1974, 43 in 1973, 12 in 1972 and 35 in 1971. Also disturbing was the refusal of three persons to attend the clinic for treatment – compulsion in such cases is hardly likely to be successful when the success of treatment depends so much on patient co-operation.

The most disturbing feature of all was the fate of 120 persons notified but who were untraceable or who decamped upon being notified. This problem applied to 19,2%/o of the notifications of persons giving a Langa address and 4,6%/o of persons giving another Cape Town address.

The problem at Langa is that most of the missing notified cases were persons whose disease was discovered by mass x-rays of a 'pre-employment' nature. These persons very often have no accurate address and may be recorded as being 'SAR' (South African Railways) or some other huge employer of labour where it is well nigh impossible to trace someone whose name may also have undergone a spelling change in the meantime.

Figure: 5.4 *MOBILISATION OF COMMUNITY RESOURCES IN THE TERTIARY PREVENTION OF TUBERCULOSIS*



No new drugs were introduced in 1976 which had not previously been used. The State Health guide to Chemotherapy (ref. Jan. 1975) was followed and in general the preferred regime for the initial intensive (I.I.T.) period of some 3 – 4 months in most cases was Streptomycin, INH and either ethambutol or ethionamide for children or pyrazinamide for adults.

Rifampicin was not used very widely and use of this drug should be expanded (under strict control and provided financial resources are available) in the next few years.

We await with great interest published work on trials of intensive short-course Chemotherapy in South African communities and although definite recommendations in this regard have been made for the United Kingdom we have adopted a conservative approach during 1976.

The number of streptomycin injections given at the various clinics in 1976 and 1975 are detailed in Table V.XVII and V.XVIII.

There was a decline in the number of Streptomycin injections of 3,4% over 1975 (despite an increase in the number of patients attending the clinics).

Two nurses were employed full-time on domiciliary treatment and gave a total of 10 417 injections in 1976.

Domiciliary injections of Streptomycin were discontinued in December 1976 as the costs did not justify this service and where it was really impossible for the patient to attend a clinic (not only the 11 TB centres but also other Council Clinics where a Clinic Sister was available), alternative drug regimes could be prescribed. The total of Domiciliary injections was also markedly depressed by the period of civil unrest.

TERTIARY PREVENTION

At this level of prevention the aims of health care in general are:

To prolong meaningful life.
To provide support in stress to the patient and his family and
to mobilise community resources to assist the individual
and persons indirectly affected by his illness.
To rehabilitate the patient and return him to his role in society as rapidly as possible.

The prolongation of meaningful life.

Fortunately tuberculosis is highly amenable to therapy, with the exception of tuberculosis meningitis which has a high mortality (increasing in relation to the delay between onset and the start of specific therapy and much higher if the patient is already comatose when treatment starts).

Nevertheless tuberculosis does still result in a number of persons becoming severely handicapped in later life – either as respiratory criples due to gross pulmonary infection or as decerebrate paralytics, paraplegics, etc., following meningitis. The cost to the individual and his family in terms of human suffering and to the community in terms of hospital costs is not inconsiderable.

Mortality from tuberculosis is dealt with elsewhere in this report (Page 59).

To provide support in stress to the patient and his family and to mobilise community resources to this end.

While the City Council and its Health Department, refunded for its costs in part by the central government, plays the major role in providing medical care for the patient, this Department concerns itself with the family of the patient as well and also mobilises other community agencies to assist patient and family in non-medical fields of need. (See Figure 5.4).

During 1976 the Care Committee for Tuberculosis Patients – a voluntary lay charitable body supported by the Community Chest and of which the Medical Officer of Health is chairman – assisted 831 families and the work done is summarised in Table V.XIX. There was a marked fall in the number of visits made by the Case Worker owing to the civil unrest in the second half of the year. A creche operated by this Committee for the children of Tuberculosis patients was unfortunately burgled so often that insurance cover was refused

and it had therefore to be closed down.

The S A N T A operated creche continued to cater for 55 children.

Rehabilitation of the Patient in the Community

This aspect of tertiary prevention commences from the moment of Notification as strenuous efforts are made to avoid hospitalisation and loss of employment.

SECTION VI

SEXUALLY TRANSMITTED DISEASES (VENEREAL DISEASES)

Many cases of sexually transmitted diseases (STD) are treated privately or not at all, and there is no compulsion to notify them all to the local authority. Accurate epidemiological trends are thus difficult to detect, since the numbers of persons making use of City Health centres in this regard may be influenced by factors other than a real change in the pattern of occurrence of Venereal Disease (V D) (e.g. altered community affluence; changing social attitudes to the stigma of these diseases; local availability of the City Health services etc). Nevertheless the attendances at Municipal clinics (euphemistically described as "Treatment Clinics" on timetables etc) provide the only major epidemiological record of these diseases in Cape Town and are presented below in order that a PRIORITY RATING may be assigned to this aspect of community health.

MORBIDITY

The numbers of new cases seen during 1976 and the preceding year are detailed by race group, sex and diagnosis in Table VI.I. Trends over a series of years are indicated in Table VI.II; and occurrence in teenagers in Table VI.III. Summary data is contained in Table VI.V.

All Forms of Sexually Transmitted Diseases

The number of new cases fell by 32 (0,245^{0}/o) from 13 017 in 1975 to 12 985 in 1976 with a concomitant fall in the incidence rate per 1 000 population from 15,9 to 15,4. White female new attendances fell by 30^{0}/o (from 50 to 35); Black/Coloured/Asian male new attendances fell by 1^{0}/o (from 10 192 to 10 125); White male new attendances rose by 0,5^{0}/o (from 387 to 389) and Black/Coloured/Asian female attendances rose by 2^{0}/o (from 2 388 to 2 436).

There were 788 new cases in teenagers in 1976, a fall of 16,3^{0}/o over the 1975 figure of 930.

The spectrum of pathology seen is illustrated in Figure 6.1.

Syphilis

There was an increase of 0,77^{0}/o (from 3 660 to 3 688) in the number of new cases of acquired syphilis in 1976 compared with 1975 (a decrease of 3 in Whites was offset by an increase of 31 in other race groups). See Tables VI.I, VI.II, VI.III and VI.VI and Figures 6.2 and 6.3. Congenital syphilis cases numbered 75 in 1976, an increase of 108,3^{0}/o over the 36 cases in 1975.

Gonorrhoea

There was a decrease of 4,4^{0}/o (from 8 770 to 8 387) in the number of new cases of gonorrhoea in 1976 compared with 1975 (an increase of 7 Whites being offset by a decrease of 390 in other race groups). See Tables VI.I – VI.III and VI.V.

No penicillinase producing Neisseria were identified during the year.

Other Venereal Diseases

There was an increase 51,5^{0}/o (from 551 to 835) in the number of new cases of veneral diseases other than syphilis or gonorrhoea in 1976 compared with 1975 (a decrease of 17 Whites being offset by an increase of 301 in other race groups). See Tables VI.I, II, III.

The increase was largely due to a rise in the number of cases of non-specific urethritis (NSU) in Black/Coloured or Asian males. See Table VI.VI.

Non-specific urethritis shows a strong downward trend as a percentage of all new cases of White Male V D and strong upward trend for males of other races.

The spectrum of diseases seen is illustrated in Figure 6.4.

Figure: 6.1 *NEW ATTENDANCES AT VENEREAL DISEASE CLINICS BY DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASE (S.T.D.) 1976*

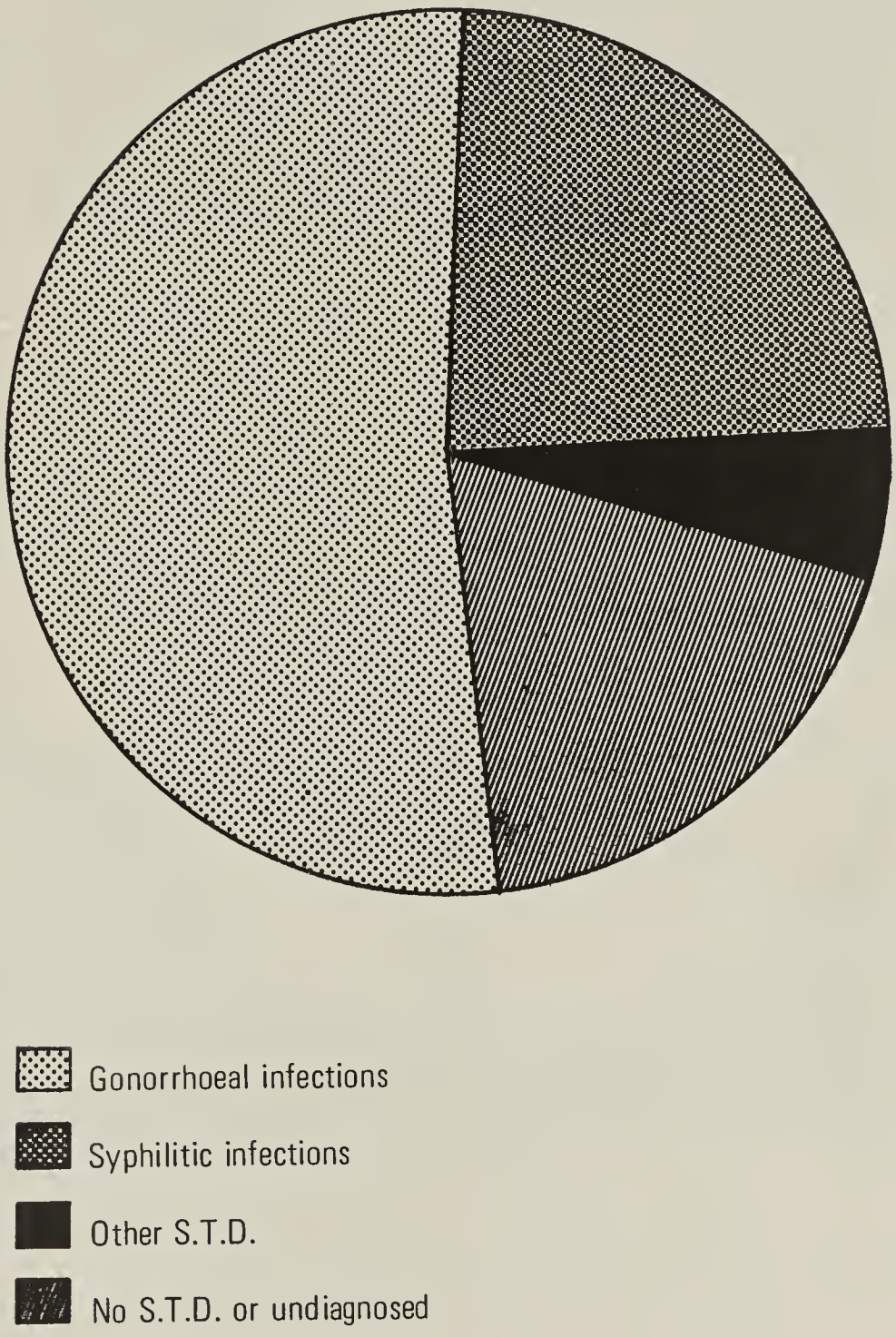


Figure: 6.2 *NUMBERS OF NEW CASES OF SYPHILIS (INCLUDING REINFECTIONS) SEEN AT VENEREAL DISEASE CLINICS BY RACE AND SEX 1950 – 1976*

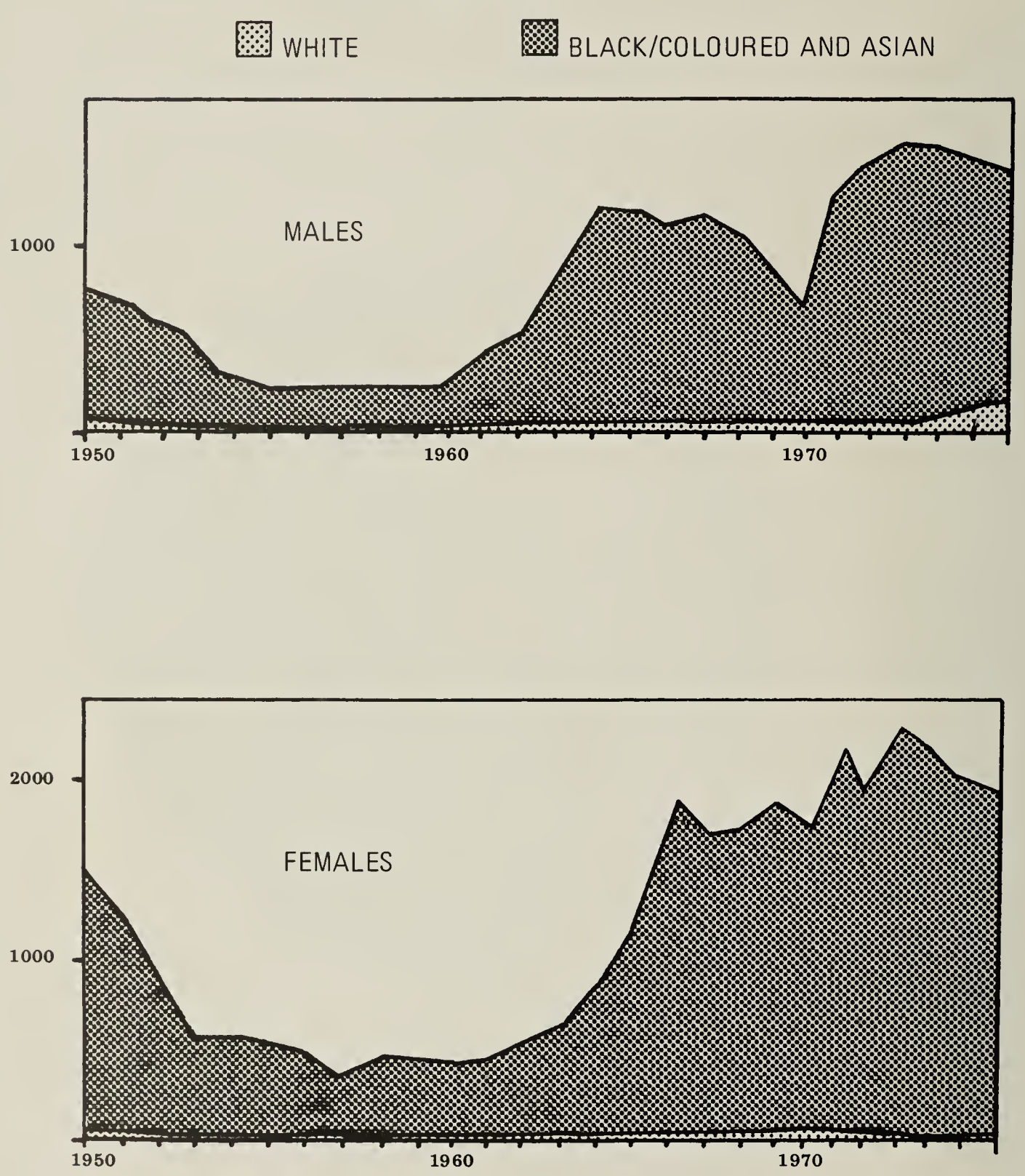


Figure: 6.3 *NEW CASES OF SYPHILIS (INCLUDING REINFECTIONS) BY FORM OF THE DISEASE: 1976*

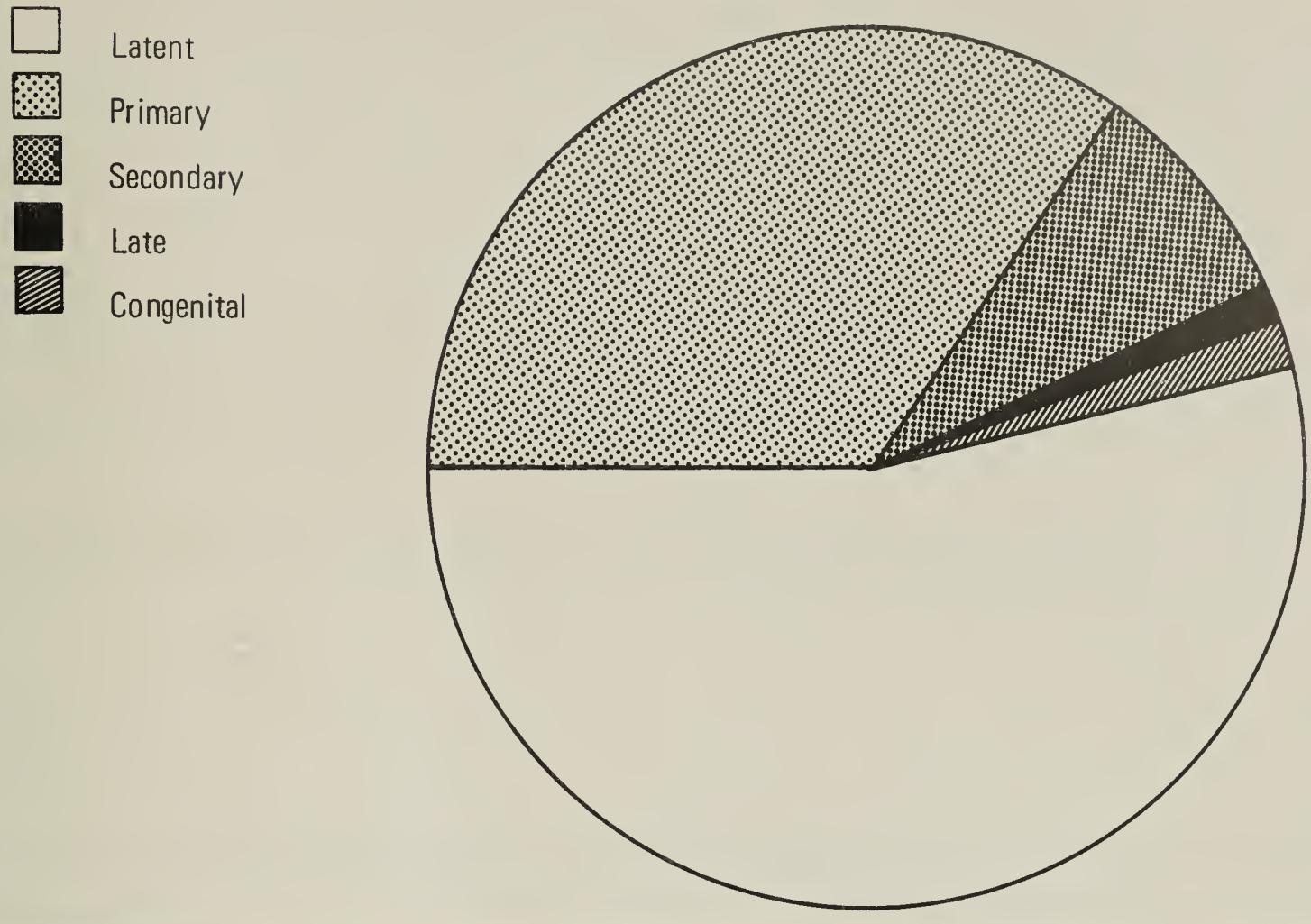
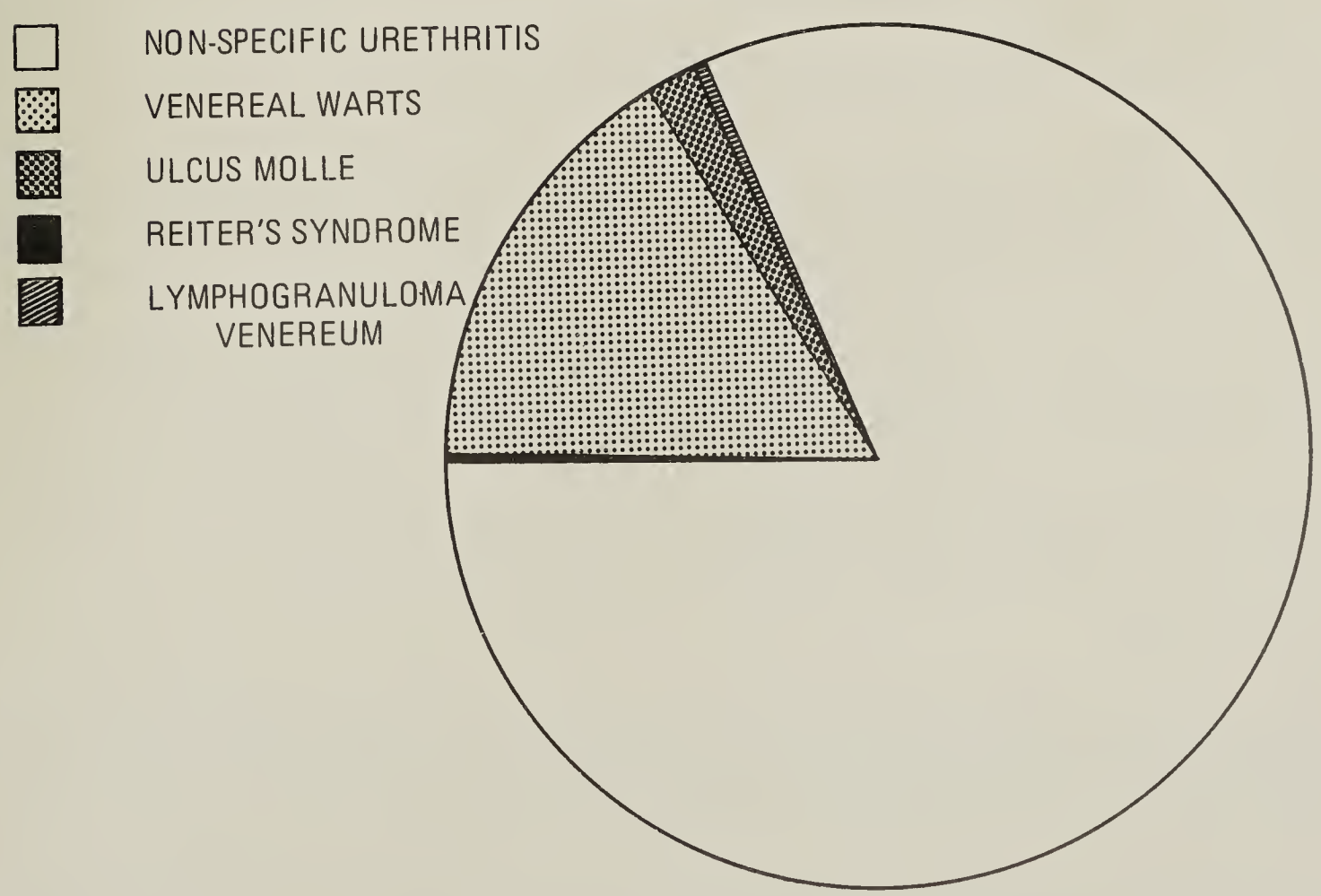


Figure: 6.4 *NEW CASES OF SEXUALLY TRANSMITTED DISEASES OTHER THAN SYPHILITIC OR GONORRHOEAL INFECTIONS (INCLUDING REINFECTIONS) BY THE DIAGNOSIS: 1976*



MORTALITY

Venereal diseases are not a significant cause of death (see Tables III.XX and III.XXIL). Three deaths due to syphilis were recorded in 1976 compared with five in 1975. Of these deaths two were due to congenital syphilis in infants under 1 year in 1976 and three in 1975.

COST FACTORS

The cost of the failure of primary prevention of the sexually transmitted diseases is difficult to compute. The major costs are psychological and social.

There is little productive working time lost due to these diseases and the treatment is not very expensive.

VULNERABILITY OF THE COMMUNITY TO V D AND SUSCEPTIBILITY OF V D TO CONTROL MEASURES

Cape Town has a number of factors favouring the continuation of the V D problem, most of which are found alone or in similar combinations elsewhere in the world.

Such factors include:

Public apathy to the effects of conditions widely believed to be eminently treatable and "not really dangerous".
The modern permissive society which contributes to the prevalence of divorce, illegitimacy and of V D.
The diminishing use of mechanical contraceptives which do offer limited protection against venereal diseases.
The absence of any health control over such phenomena as prostitution which is made inevitable by the strictly repressive social and legislative milieu.
The exposure of the population to continual infection via its port facilities.
The problems attendant upon the migrant labour system.
The failure of the human body to develop immunity to subsequent attacks of V D.
The lack of any effective immunising agents.

These factors make the prognosis for the future control of sexually transmitted disease a poor one.

PREVENTION OF THE SEXUALLY TRANSMITTED DISEASES IN CAPE TOWN

Primary Prevention

Health education in these matters forms part of the general activity of health personnel (see Section IV).

The agents of V D cannot be eradicated from the environment and the host cannot be naturally or artificially immunised. The only specific measures which can be taken in fact are to prevent the agent from surviving transfer to a new host (e.g. possibly condoms, copper T devices etc) and by treating expectant mothers with serological evidence of syphilis so that the spirochaete does not infect the foetus (or, if it has infected the foetus, the treatment is curative).

Use of condoms is not popular at City Health Department Family Planning clinics. The ante-natal serological diagnosis of syphilis has been discussed on page 43.

Secondary Prevention

Free facilities for the diagnosis and treatment of sexually transmitted diseases were provided at 27 weekly medical sessions (6 for Whites and 21 for other races) held at ten venereal disease centres (being at the City Hospital, Salt River, Wynberg, Kensington, Guguletu, Heideveld, Silvertown, Retreat, Langa and Lavender Hill) as well as a ante-natal clinics held elsewhere (see page 43) during 1976.

The workload at the venereal disease centres increased slightly in 1976 compared with the previous year; new attendances increasing by 1,4% from 15 748 to 15 969 (although White new attendances fell by 7,2% from 622 to 577, new attendances by other races increased by 1,8% from 15 126 to 15 392) and total attendances increasing by 1% from 37 304 to 37 680 (White total attendances fell by 1 1/2% from

1 774 to 1 748 but total attendances for other races rose by 1,1% from 35 530 to 35 932).

Early diagnosis

The sexually transmitted diseases embrace a wide and diverse spectrum of clinical entities. The possibility of such a disease being present should always be borne in mind.

Investigation of suspects

Many cases are investigated by their private medical attendants or by staff of other Public Health Service facilities. Good liaison exists between the Day Hospitals Organisation of the Cape Provincial Administration and this Department, whereby cases diagnosed at such hospitals are started on treatment (which at least renders them non-infectious and may even cure the patients even if they default at this stage) and are referred to City Health clinics for continuation of therapy.

No account can be given in this years report as to the source of the new attendances recorded at the various City Health clinics. Many came with proven diagnoses, other were diagnosed clinically and yet other cases required special examination (see Table VI.VIII).

The investigation of high risk groups

Contacts

Every effort is made to inform contacts of the need for investigation. In 1976 only 283 such persons responded in contrast to the total of 12 985 new cases registered (comparable figures in the previous year were 313 and 13 017).

The expansion of the comprehensive Community Health Care Service will progressively involve many more Health Visitors in the search for contacts. (See Table IV.XIV).

Of the 283 contacts who attended clinics, (see Table VI.IX) only 3 were free of V D.

Other high risk groups

Serological screening of all ante-natal cases (see Page 43) who are not referred to other centres for their total management is performed at the clinics.

It is not possible to identify individuals at high risk although Health Education should make members of such high risk groups as prostitutes, seamen, the promiscuous etc aware of the need for regular medical investigation.

Prompt institution and maintenance of effective therapy

Treatment followed the guidelines of the State Health Department and was offered at the 10 centres detailed in Table VI.VII as well as at ante-natal clinics if held elsewhere (see Table IV.V).

Refinement of statistical data should be possible with the aim of delineating what proportion of cases received full courses of treatment, how many were reinfections etc.

Tertiary Prevention

Support in stress is offered to patients and emphasis is laid on the preservation of confidentiality. Health education directed at preventing recurrences is attempted but rehabilitative measures are not highly successful.

SECTION VII

NOTIFIABLE CONDITIONS

During the year under review, 29 conditions were Notifiable in terms of the Public Health Act in the Cape Town Municipal area; these are listed, together with legislative references, in Table VII.I.

No cases of Anthrax, Brucellosis, Cholera, Encephalitis, Erysipelas, Glanders, Lead Poisoning, Malaria, Plague, Rabies, Relapsing Fever, Sleeping sickness (Trypanosomiasis), Smallpox, Trachoma, Typhus or Yellow Fever were Notified as having occurred in Municipal residents during 1976.

Those cases of Notifiable disease which were Notified during the year are detailed according to race in Table VII.II and are ranked in order of the highest incidence thus:—
Tuberculosis, Cerebrospinal Fever, Viral hepatitis, Scarlet Fever, Ophthalmia neonatorum, Whooping cough, Typhoid Fever, Diphtheria, Poliomyelitis, Tetanus, Leprosy, Puerperal Fever and Insecticidal poisoning.

Notifications are analysed as regards the month Notification was received, the age of cases and the Municipal Ward in which they were domiciled in Tables VII.III, VII.IV and VII.V respectively.

The 196 deaths due to Notifiable diseases which were registered during 1976 included 168 due to Tuberculosis (all forms), 23 due to Cerebrospinal Fever, 3 due to viral hepatitis and 1 each due to Diphtheria and Tetanus. In 1975, 181 such deaths were registered including 168 due to Tuberculosis (all forms) 5 due to Cerebrospinal Fever, 4 due to Viral hepatitis, 2 due to Tetanus and one each due to Typhoid Fever and Diphtheria. The only marked change occurred in Cerebrospinal Fever mortality (see below).

It is difficult to gauge the amount of morbidity occasioned by conditions which are not Notifiable in terms of the Public Health Act. An indication of the importance of certain conditions can however be obtained by study of hospital admission statistics and Mortality data, (as in Section VIII).

Measles (ICD code 055), Influenza, bronchitis and pneumonia (ICD code 561, 563, 000, 004, 006-009) are three diseases/disease groups which classically produce a significant amount of illness in Cape Town.

Discussion on measles immunisation (page 48), hospitalisation (page 91) and deaths (page 32); influenza and pneumonia mortality (page 32); and diarrhoeal disease mortality (page 32) supports the contention that these remain important conditions locally.

TUBERCULOSIS (All Forms)

This disease was responsible for 85,7^{0}/o of deaths due to, and 87,25^{0}/o of all Notifications made of, Notifiable conditions in 1976. (See Table VII.II). It is discussed in full in Section V (page 56) and Table V.I).

CEREBROSPINAL FEVER

Priority rating

There was a rise in the incidence of cases of this disease in 1976 (see Figure 7.1 and Table VII.VII) to the highest figure since 1969. There were 120 cases amongst municipal residents (compared with 72 in the previous year) being 11 White, 83 Coloured and 26 Black persons (compared with 10 White, 58 Coloured and 4 Black persons in 1975).

The rise in the incidence rate per 100 000 population per year from 1975 to 1976 for Whites was negligible (from 4 to 4,3); for Coloureds was marked (from 13 to 17); and for Blacks was very great (from 4 to 25).

Not only were there more cases in 1976 but the number of deaths increased significantly from 5 in 1975 to 23 in 1976. This represents an increase in death rate per 100 000 population per year from 0,61 to 2,73 and in the mortality of Notified cases from 6,94^{0}/o to 19,17^{0}/o.

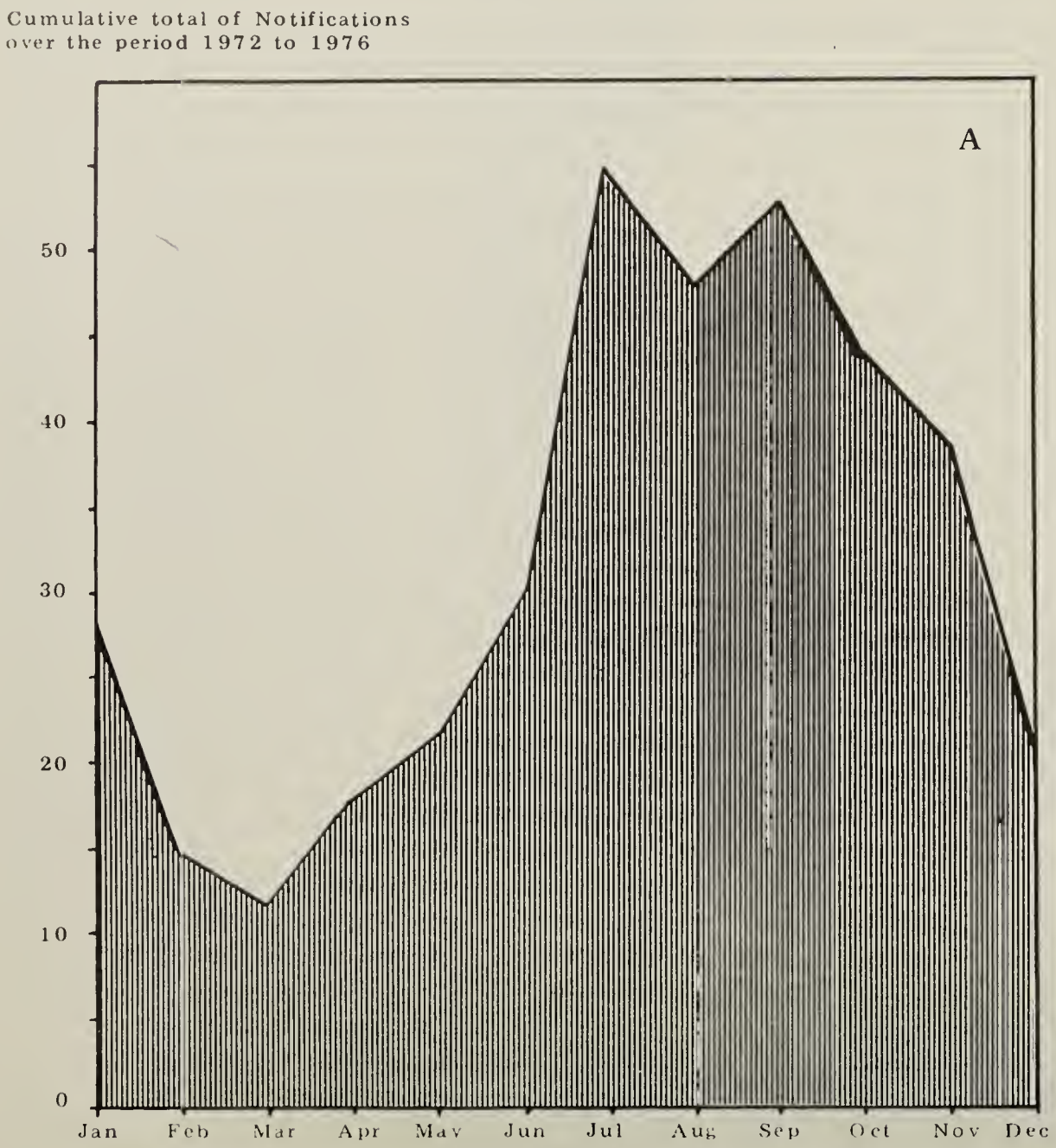
These morbidity and mortality figures indicate a high priority rating for control of this condition.

Figure: 7.1 *NOTIFICATION RATES PER 100 000 POPULATION OF CEREBROSPINAL FEVER, BY RACE: 1966 – 1976*

Figure: 7.2 *NOTIFICATIONS OF CEREBROSPINAL FEVER CASES BY MONTH OF RECEIPT OF NOTIFICATION*

A – CUMULATIVE TOTALS FOR THE FIVE YEARS: 1972 – 1976

B – FOR THE YEAR 1976 ONLY



Further Comment

The seasonal variation in Notifications of Cerebrospinal Fever is demonstrated in Table VII.III and Figure 7,2. Nearly 70^{0}/o of the number of cases from 1972 – 1976 occurred in the half year June to November, co-inciding with the cooler wetter months.

Prevention

Overcrowding, especially in colder weather, is unavoidable for large sections of the Community under present Housing circumstances. Housing standards, unattainably high in the present crisis, are essential to reduce morbidity and mortality from this disease. An urgent plea is made for the acceptance of the basic formula of:–

(a) Core Housing
(b) Security of tenure
(c) Provision of essential services in suitable areas now.

Specific measures to prevent the disease developing in the general Community are difficult to apply. Chemotherapeutic prophylaxis is employed promptly and intensively by the City Health Department to protect contacts of notified cases. Liaison with the State Health laboratory is necessary to ensure that sulphonamide resistant strains have not appeared.

Careful search for additional cases is made amongst contacts of Notified cases and health education employed to ensure early reporting of any malaise.

The institution of prompt and effective therapy is vital to prevent a high mortality. Most cases were seen initially at general hospitals, or occasionally by private practitioners, and 20 of the Municipal cases were treated at General Hospitals for the whole of their illness (usually because they were too ill to be moved) while 100 were admitted to the City Hospital (in addition there were 119 cases from outside the Municipal area who were admitted to the City Hospital; 8 of these died to give a mortality of 6,7^{0}/o of out of City cases, which was much lower than that of 19,17^{0}/o for the local cases).

VIRAL HEPATITIS

Priority rating

This disease has only been Notifiable since 1969–05–30. The Incidence and Mortality since then is detailed in Table VII.VI and Figure 7.3.

In terms of morbidity and mortality, Viral Hepatitis ranked third in importance amongst the Notifiable diseases in Cape Town in 1976. There were 102 cases (28 White, 58 Coloured, 14 Black and 2 Asian) compared with 99 cases in 1975 (30 White, 60 Coloured, 9 Black, 0 Asian).

Incidence rates per 100 000 population fell slightly for Whites (from 12,2 to 12) and Coloureds (from 13,04 to 12,15) but rose for Blacks (from 9,21 to 13,93) and the incidence rate per 1000 persons rose for Asians (from 0 to 0,18).

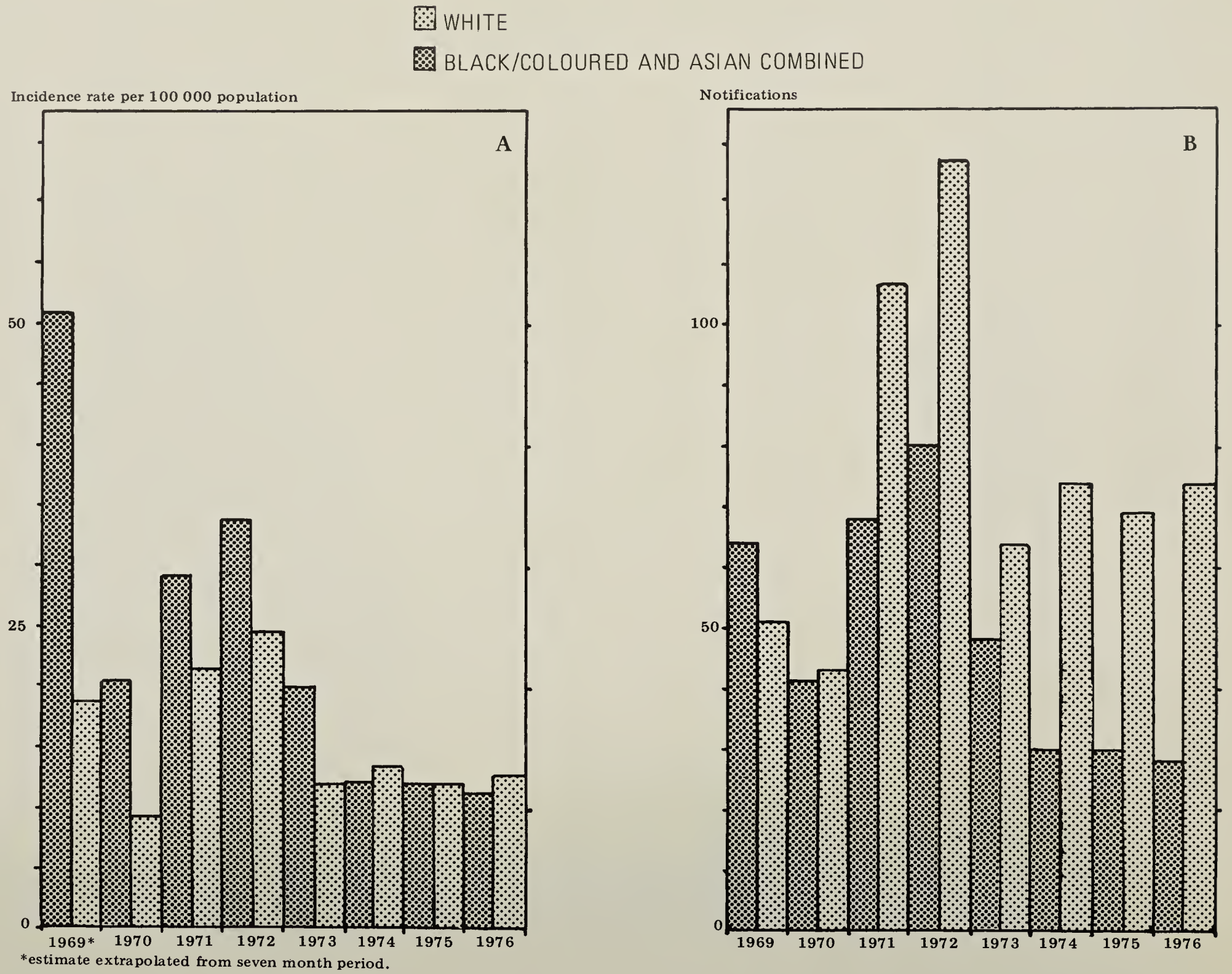
Deaths due to Viral Hepatitis in 1976 numbered 3 compared with 4 in 1975 (see Table VII.VI). Since 1969 there have been a total of 1001 (392 White and 609 Coloured, Black or Asian) cases Notified of whom 39 (10 White and 29 Coloured/Asian or Black) died – a significant mortality of nearly 4^{0}/o. (3,04^{0}/o for Whites and 4,76^{0}/o for other races combined).

Prevention

Infective hepatitis (Hepatitis A) is usually spread by the faecal-oral route and general measures to prevent it include health education, attention to personal hygiene and control of food handling. No vaccine is available.

Early diagnosis and treatment is usually a function of other medical services. In 1976 only one case was admitted to the City Hospital, 16 were admitted to General Hospitals and the remainder were treated at home. Admission to hospital is usually for reasons of severity of illness or because the patient lives in an

Figure: 7.3 *ANNUAL INCIDENCE RATES PER 100 000 POPULATION (A) AND NUMBERS OF NOTIFICATIONS RECEIVED (B) OF VIRAL HEPATITIS, BY RACE GROUP: 1969 (from May 30th) to 1976.*



*estimate extrapolated from seven month period.

institution with no facilities for isolation.

SCARLET FEVER

Priority rating

There was a minor epidemic of Scarlet Fever Notifications in 1976 with 101 episodes of the disease being Notified in 100 persons (one had two attacks probably because penicillin therapy was commenced so early with the first attack that no immunity developed).

The annual Notifications and Incidence rates per 100 000 population of Scarlet Fever from 1966 – 1976 are detailed in Table VII.VI. The Incidence rates from 1957 – 1976 are illustrated in Figure 7.4 for Whites only (because it was in this group that the epidemic was recorded; however it is certain that difficulties in detecting Scarlatiniform rashes in dark-skinned persons leads to under-Notification of this condition in groups other than Whites).

The higher incidence of Scarlet Fever gave an indication that the general incidence of Streptococcal throat infection was also raised; this latter condition is not Notifiable but is a Scheduled disease in terms of the Regulations governing exclusion from schools.

There have been no deaths in Cape Town which were directly attributable to an attack of Scarlet Fever since 1960. Nevertheless, Rheumatic heart disease (which may have resulted from Scarlet Fever or another Streptococcal infection) remains an important cause of morbidity and mortality.

Prevention of Streptococcal infections and of their sequelae

NB. Although the risk of developing a non-suppurative complication of antecedent Streptoccal infection is low, it is a real one and every effort was made to minimise this risk. Adequate therapy with penicillin or erythromycin was called for to prevent the development of acute rheumatic Fever or glomerulonephritis.

General measures taken included advice to public, parents and Headmasters about the necessity for personal hygiene and the avoidance of pencil-sharing etc. Here both Press and Radio were very helpful.

There is no available vaccine to protect against the $\pm$ 50 serotypes of streptococci which could have been involved.

Publicity given to the outbreak no doubt increased awareness of the disease and favoured its diagnosis and Notification.

Therapy was administered at home by the patients private medical attendants and publicity was given to the recommendations of international authorities in this field in order to prevent complications.

OPHTHALMIA NEONATORUM AND GONOCOCCAL OPHTHALMIA

Definitions – Ophthalmia neonatorum is a purulent inflammation of the eyes in an infant up to 21 days old whether the infection is due to Neisseriae gonorrhoea or not.

Gonococcal ophthalmia is a purulent inflammation of the eyes due to Neisseriae gonorrhoes at whatever age this occurs.

Priority rating

During 1976 there were 18 cases (14 Coloured and 4 Black) Notified of Ophthalmia neonatorum.

The significance of this disease lies in the fact that the mother probably had inadequately treated or untreated gonorrhoea at the time of parturition and that the infant did not receive proper prophylactic care after delivery.

Prevention

Ante-natal diagnosis and cure of maternal gonorrhoea prevents cases.

Figure: 7.4 *ANNUAL INDICENCE RATES PER 100 000 POPULATION OF SCARLET FEVER NOTIFICATIONS, WHITES: 1957 – 1976*

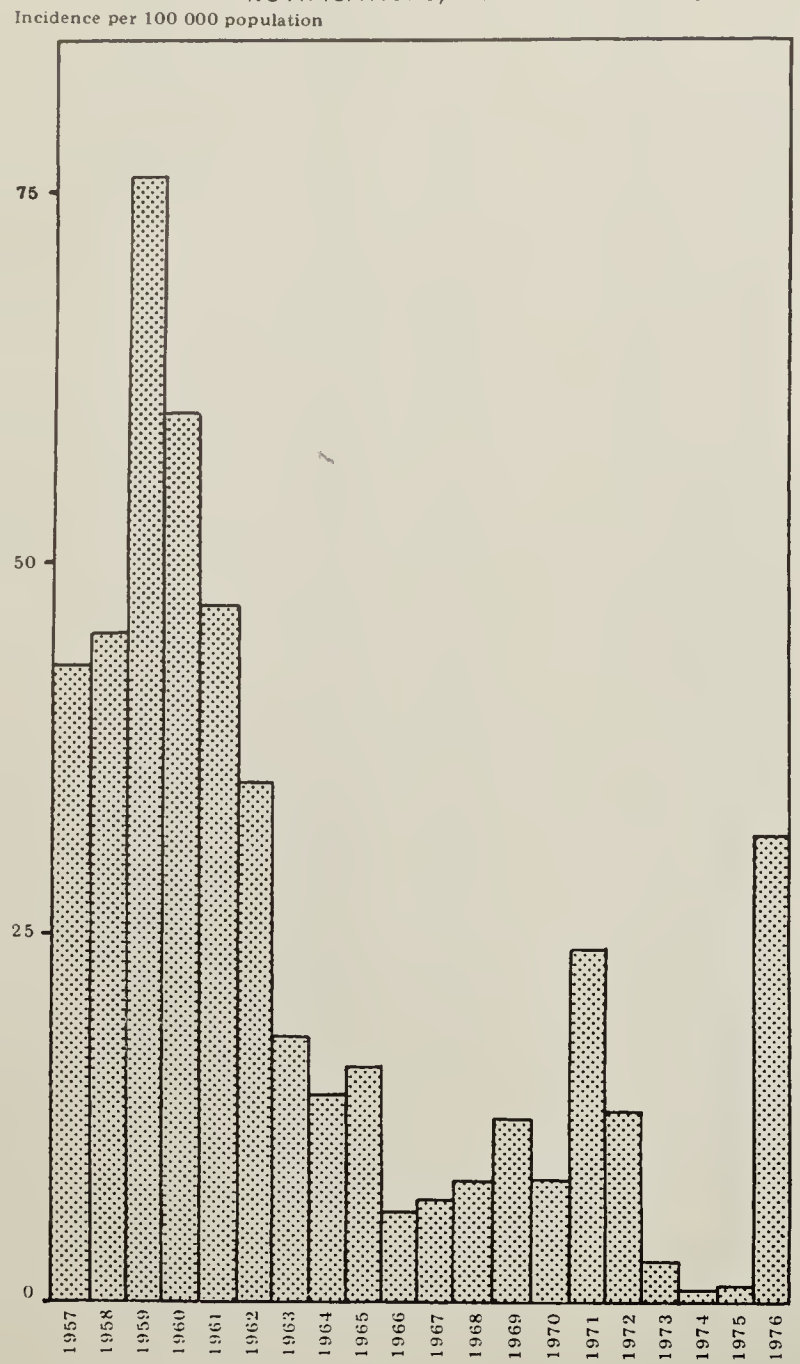
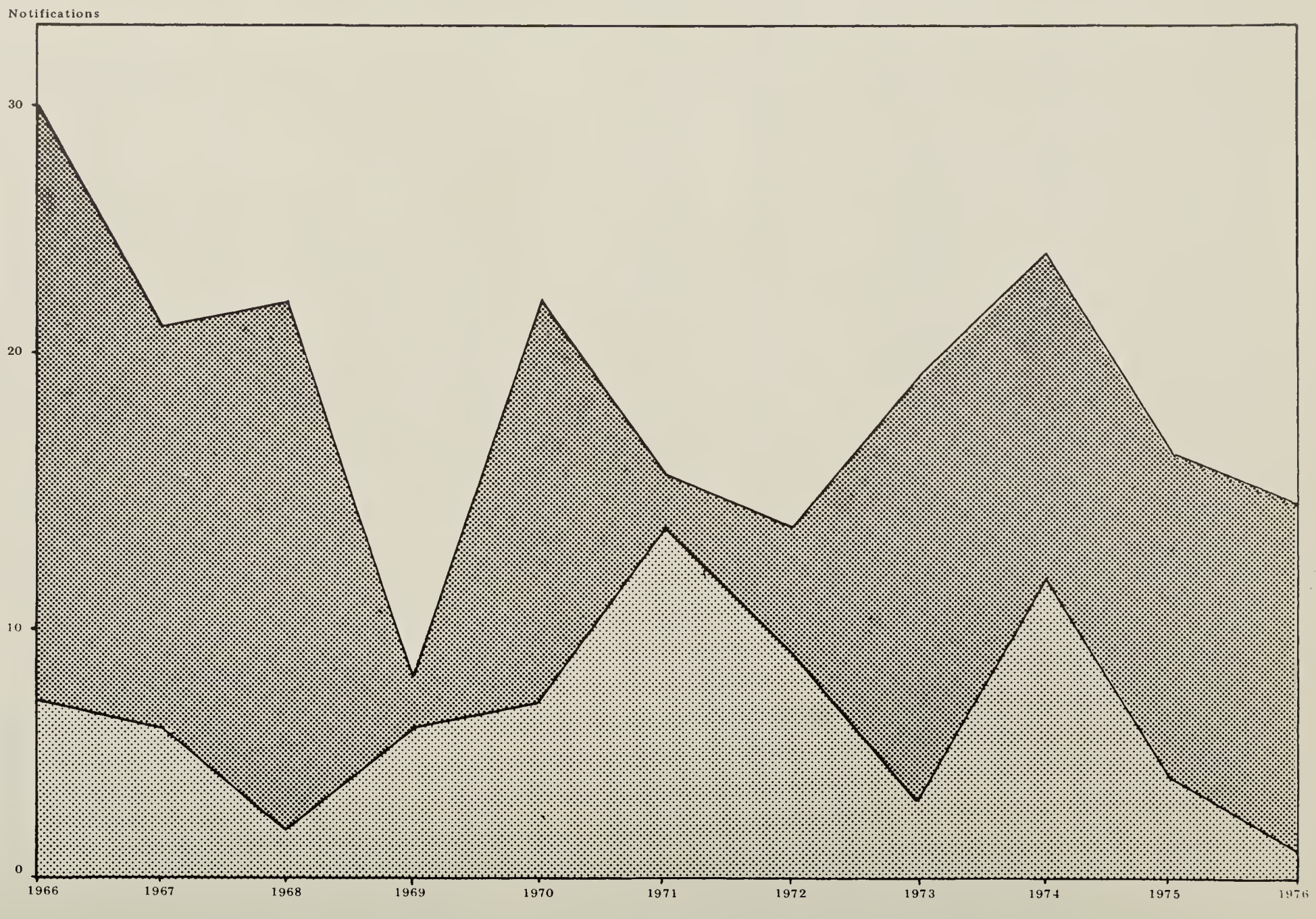


Figure: 7.5 *ANNUAL NOTIFICATIONS OF WHOOPING COUGH, BY RACE GROUP: 1966 – 1976*



Instillation of chloromycetin applicaps into the eyes of all neonates as a chemoprophylactic measure.

The birth attendant must check the condition of the neonates eyes and report any inflammation no matter how slight to a medical practitioner to ensure early diagnosis and treatment.

WHOOPING COUGH

Whooping Cough is a clinical syndrome classically associated with Bordetella pertussis, B. parapertussis and viruses such as adenovirus.

Priority rating

The pattern of the previous few years (see Figure 7.5 and Table VII.VI) was maintained in 1976, with 15 cases being Notified (1 White, 9 Coloured and 5 Black) giving Incidence rates per 100 000 population per year of 0,39 for Whites, 1,88 for Coloureds and 4,97 for Blacks.

There were no deaths due to this disease during 1976 although there have been 17 deaths from 1967 – 1976; which represented 7^{0}/o of the total of 244 Notified cases over the past decade.

Prevention

Immunisation remains important in Cape Town. There has been considerable debate in the British medical press as to the desirability or otherwise of continuing to offer routine immunisation against B. pertussis infection. No change in local policy is anticipated.

Reduction in the risk of infection of other pupils is made possible by excluding patients and contacts from schools.

Early diagnosis is made clinically and patients are admitted to the City Hospital as Whooping Cough cases without the necessity for bacteriologic proof of the diagnosis. Apart from the local cases admitted, there were 26 (3 White and 23 of other race groups) cases admitted to the City Hospital from outside the Municipal area. Treatment with ampicillin or erythromycin and skilled nursing care is essential and it was encouraging that despite the 7^{0}/o mortality rate calculated above, the "1.19 expected deaths" did not occur.

TYPHOID FEVER

Priority

The number of Notified cases of Typhoid Fever in 1976 (9 – 1 White, 5 Coloured and 3 Black) was the lowest since 1969.

Annual Notifications and Incidence rates per 100 000 population for the past decade are detailed in Table VII.VI and illustrated in Figure 7.6.

The average incidence per year per 100 000 population 1967 – 1976 was 0,34 for Whites and 2,86 for all other race groups combined.

There were no deaths in 1976 and of the 152 cases Notified from 1967 – 1976 only 2 died (1^{0}/o).

Prevention

The pillars of Typhoid prevention are proper sewage disposal, a pure water supply and strict control over milk and dairy products. The housing shortage in Cape Town leaves many areas e.g. Squatter camps, in danger. Constant vigilance is needed here.

Specific protection can be obtained to some extent by immunisation. Vaccines are not 100^{0}/o successful. Exclusion of cases and contacts from food-handling and institutions reduces the risk of spread.

Typhoid is endemic in Cape Town. An active search for new cases and carriers is made amongst contacts of Notified cases. Two carriers were diagnosed and admitted for treatment to the City Hospital. A full record

Figure: 7.6 *ANNUAL INCIDENCE RATE PER 100 000 POPULATION (A) AND NOTIFICATIONS (B) OF TYPHOID FEVER, BY RACE GROUP: 1967 – 1976*

WHITE

BLACK/COLOURED AND ASIAN COMBINED

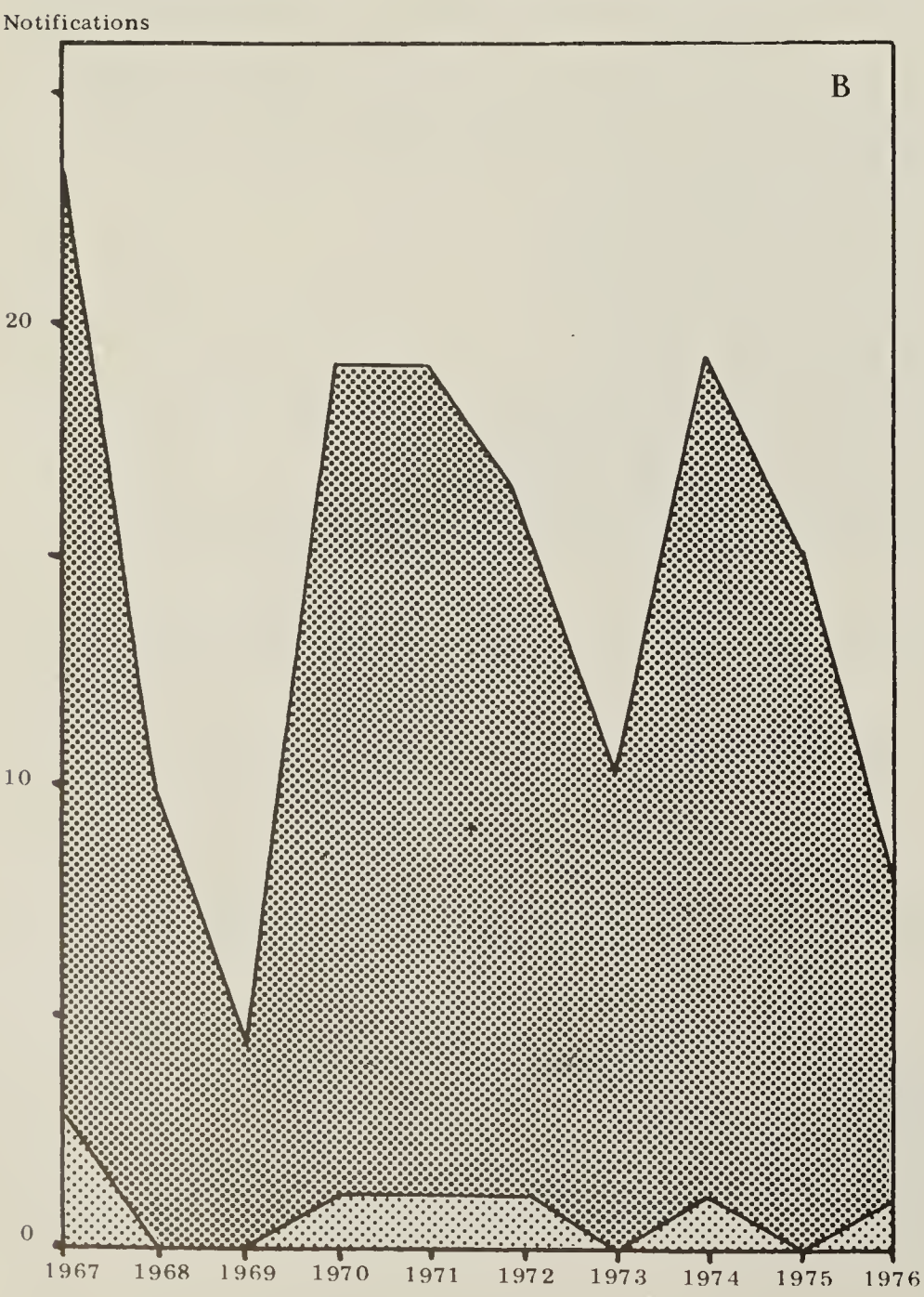
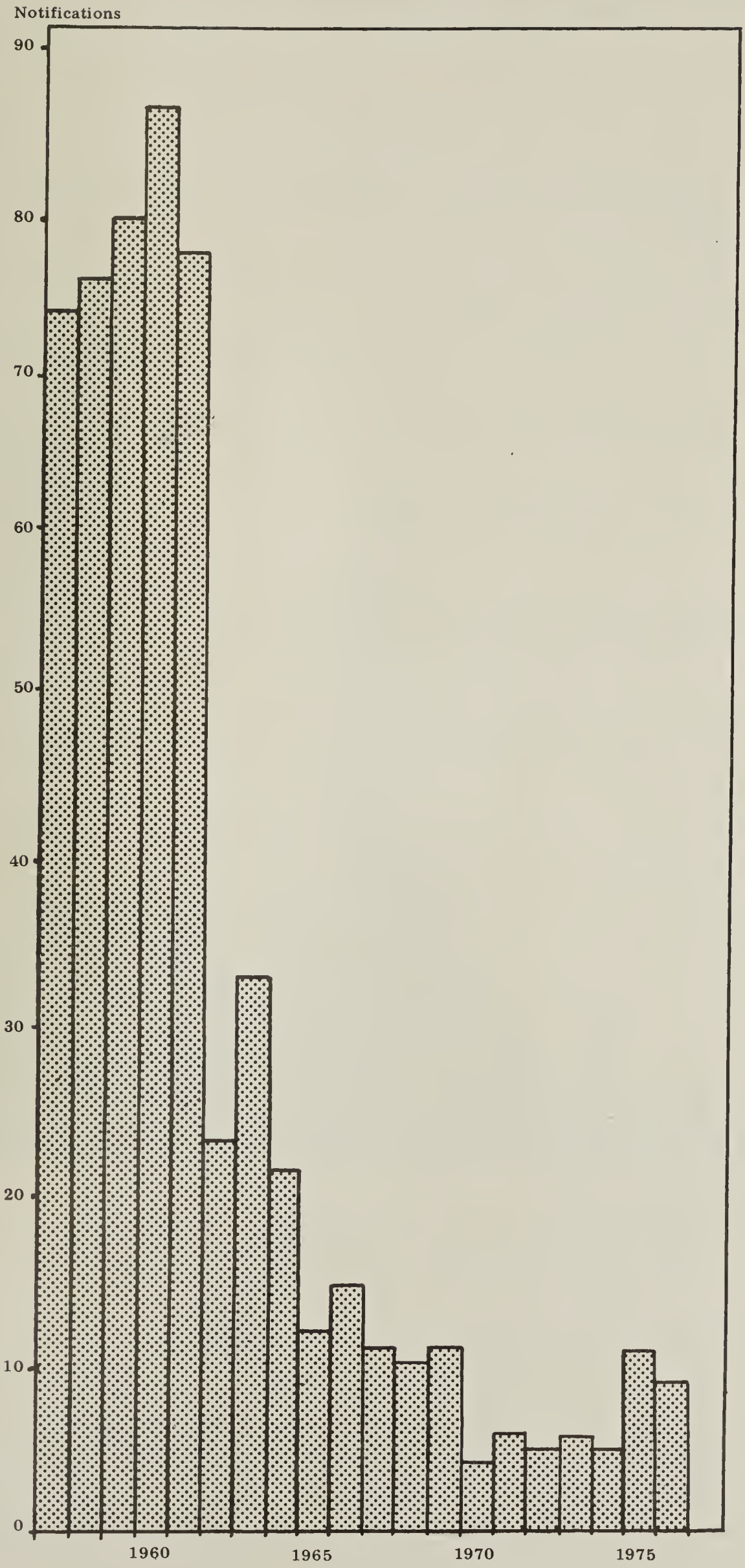


Figure: 7.7 *ANNUAL NOTIFICATIONS OF DIPHTHERIA, ALL RACES 1957 – 1976*



of all carriers is maintained and they are kept under observation.

In addition to the local cases, the City Hospital admitted 20 non-resident cases during 1976 (compared with 149 in the previous year during the Stellenbosch Divisional Council epidemic).

DIPHTHERIA

Priority rating

This terrible disease had been so tamed by immunisation that Notifications have fallen from 770 cases in 1940/1941 to between 4 and 11 cases each year of the past decade. The fall in Notificaitons over the past twenty years is dramatic enough (Figure 7.7).

There were 9 cases (7 Coloured and 2 Black) Notified in 1976. The incidence rates were 0; 1,46 and 1,99 per 100 000 population for Whites, Coloureds and Blacks respectively.

Four of the cases had been partially immunised and no records were available in respect of the other five.

There was one death in 1976 although of all the 78 cases Notified from 1967 – 1976 only 6 died (7,7^{0}/o). Deaths since 1914 are illustrated in figure 7.8.

Notifications and Deaths for the past decade are detailed in Table VII.VI.

Prevention

The big danger of a resurgence of this disease lies in parent complacency. The Child Welfare staff constantly seek to ensure that every child is **fully** immunised – nothing less is satisfactory.

Details of immunisation are to be found on page 46 and in Table IV.IX and b) c) d).

Cases, contacts and carriers are excluded from institutions to prevent spread – 6 carriers were Notified in 1976 (3 Coloured and 3 Black).

Early diagnosis is essential. Anti-toxin is given when any doubt exists because of the serious consequences of delayed therapy.

In addition to the local Notified cases, there were 5 non-resident cases admitted to the City Hospital from outside the Municipal area.

POLIOMYELITIS
(Acute anterior poliomyelitis)

Priority rating

There were 6 cases (2 Coloured and 4 Black) Notified in 1976 – two were partly immunised and there were no records of the other four cases.

The occurrence of poliomyelitis in Cape Town since 1915 is illustrated in Figure 7.9 and the Incidence rates per 100 000 population 1967 – 1976 in Figure 7.10. Table VII.VI details Notifications, incidence rates and deaths for the past decade.

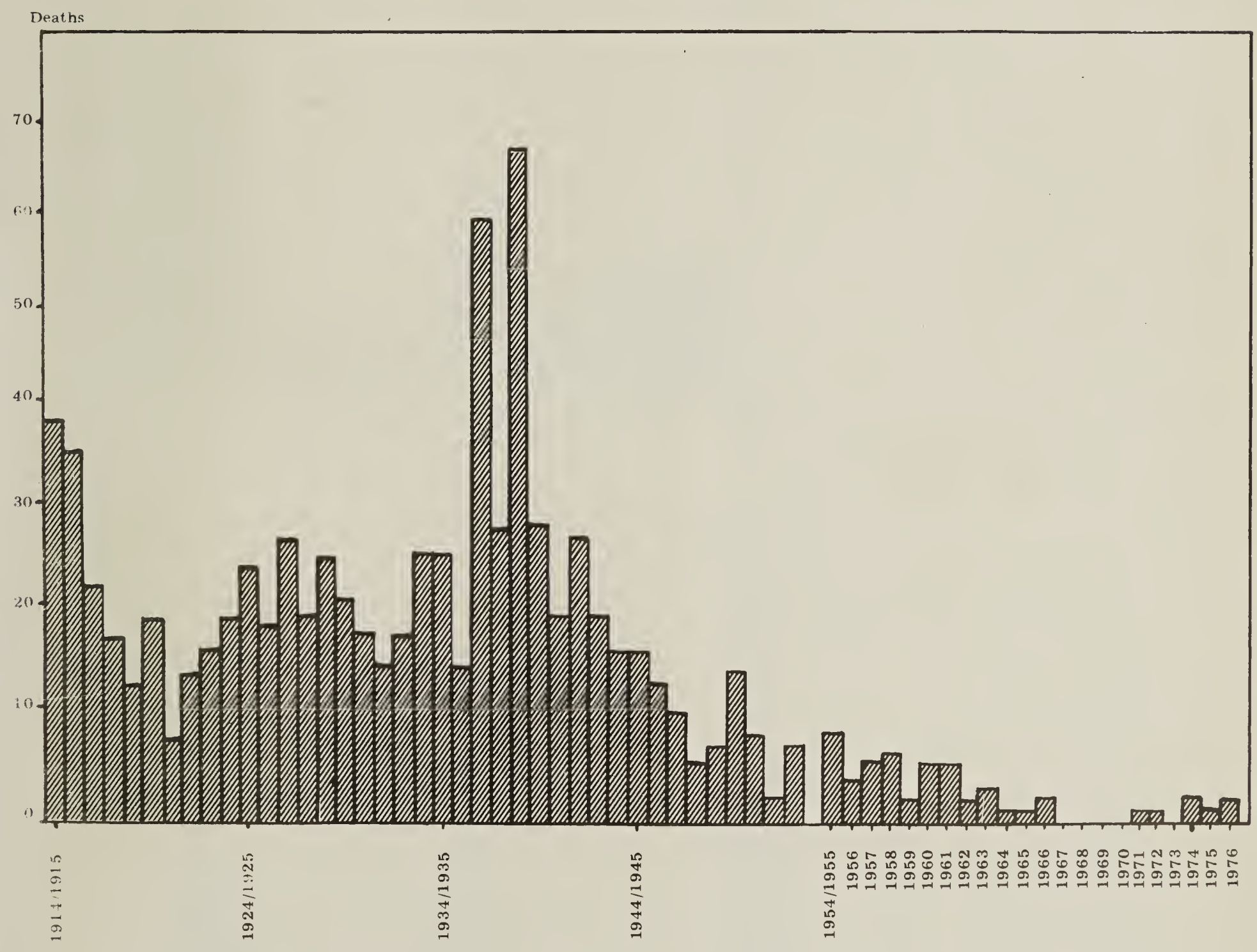
There were no deaths in 1976 and of the 58 cases Notified since 1967 only 2 died (3,5^{0}/o).

Prevention

Specific protection by means of the live attenuated oral poliovaccine has been the mainstay of preventive measures since 1961. Details are contained in Table IV.IX and see page 46.

The practice of giving four doses of oral vaccine was discontinued at the request of the State Health Department and only three doses were given as a routine during the year under review.

Figure: 7.8 *ANNUAL TOTALS OF REGISTERED DEATHS DUE TO DIPHTHERIA: 1914/1915 – 1976*



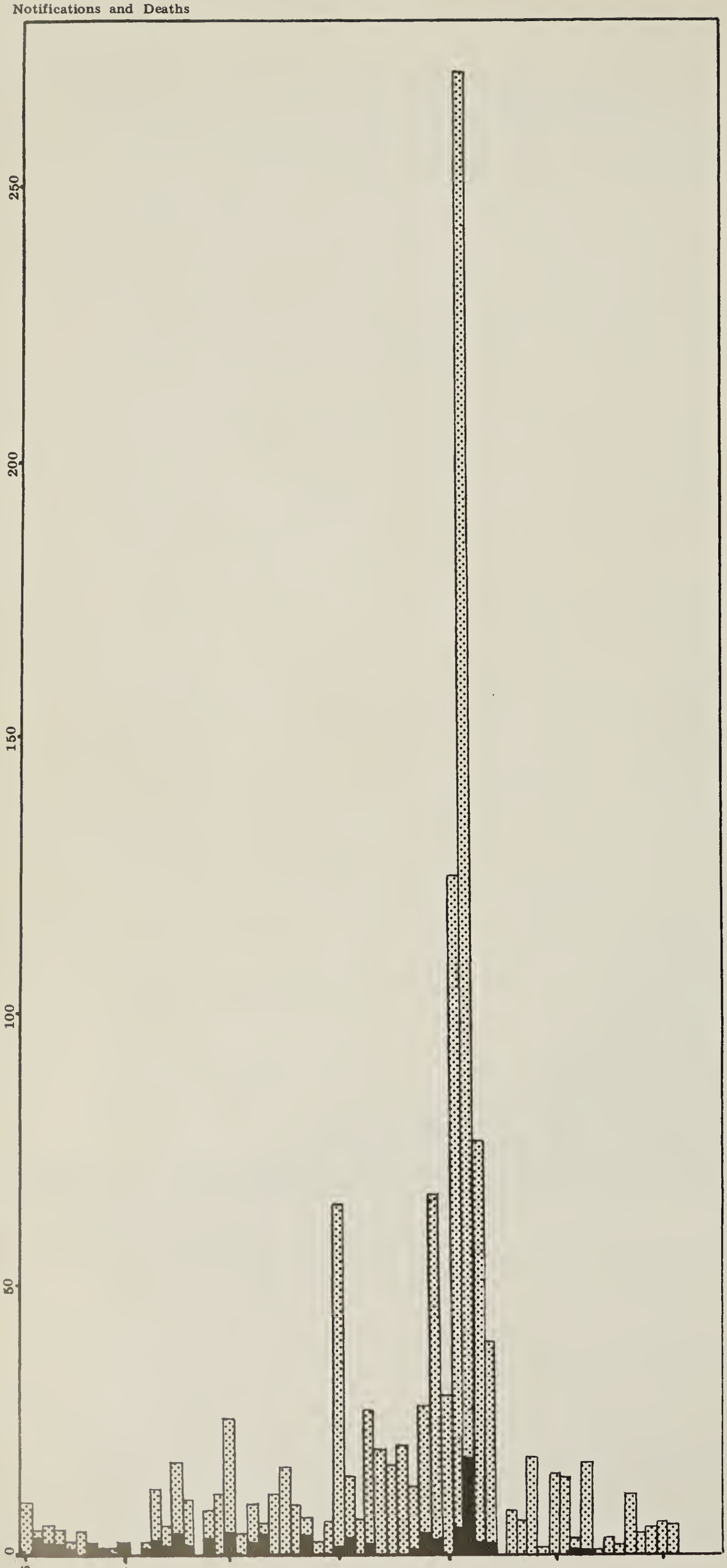


Figure: 7.9

NOTIFICATIONS AND DEATHS FROM ACUTE POLIOMYELITIS: 1915 – 1976

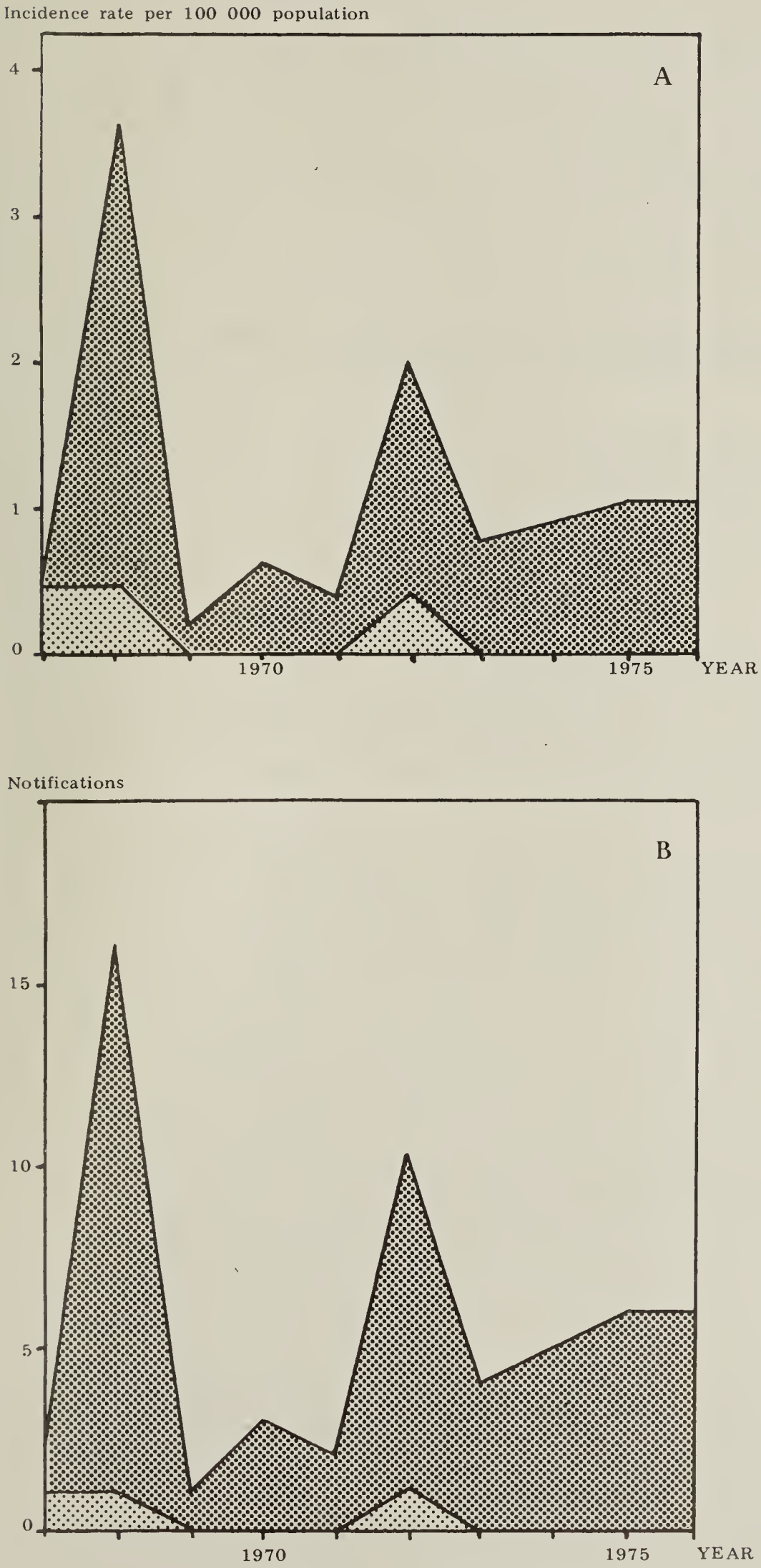
NOTIFICATIONS

DEATHS

Figure: 7.10 *ANNUAL INCIDENCE RATES PER 100 000 POPULATION (A) AND NOTIFICATIONS (B) OF ACUTE POLIOMYELITIS: 1967 – 1976*

WHITE

BLACK/COLOURED AND ASIAN COMBINED



Poliovirus is ubiquitous in the Community and isolation of cases does little to prevent spread. Contact follow-up and immunisation are important.

In addition to the local cases there were 35 cases admitted to the City Hospital from outside the Municipal area (compared to only 8 in the previous year).

TETANUS (AND TETANUS NEONATORUM)

Priority rating

This disease should not occur in a modern community which has been fully immunised.

There were two cases of tetanus (including one of tetanus neonatorum) in Cape Town in 1976, one of whom died.

Notifications and deaths are detailed in Table VII.VI for the period 1967 to 1976.

Over the last decade there have been 40 cases of whom 13 died (33%).

Intensive immunisation against the tetanus toxin is carried out on all neonates. See Table IV.IX and page 46. . Tetanus toxoid boosters and prophylactic injections at time of the injury are also essential in later life.

Treatment of tetanus cases is a function of general hospitals as they are not infectious. Treatment of established tetanus has poor results.

LEPROSY

Priority rating

The two cases Notified in 1976 contracted their disease elsewhere.

In the period 1967 – 1976 there have been 10 cases notified, none of whom definitely contracted their disease locally.

Prevention

Good personal hygiene is sufficient to protect against this not highly infectious disease.

All cases are referred for treatment by the Central Government at Westfort near Pretoria.

PUERPERAL FEVER

Priority rating

There was one case Notified in 1976, who survived.

In the period 1967 – 1976 17 cases were Notified and there was one death (6%).

Investigation of birth attendants to detect Streptococcal carriers is carried out routinely in such cases.

Prevention

No specific protection is possible. General hygienic measures should prevent the disease and birth attendants should be checked for the nasopharyngeal carrier state.

Cases are treated in general hospitals and are no longer admitted to the City Hospital.

INSECTICIDAL POISONING

Priority rating

There was one case Notified in 1976, who survived.

In the period 1967 – 1976 3 cases were Notified and there were no deaths.

It is suspected that more cases have occurred but were either not diagnosed or not Notified.

Prevention

Great care in the manufacture, packing, storage, distribution, usage and processing of protected products (e.g. fruit and vegetable washing etc.) is necessary to prevent the agent of disease coming into contact with the consumer or handler.

OTHER NOTIFIABLE DISEASES

There were no cases of anthrax, brucellosis, Asiatic cholera, glanders, plague, rabies, relapsing fever, sleeping sickness (human trypanosomiasis), smallpox, trachoma or yellow fever Notified in municipal residents over the decade 1967 – 1976.

In the same period there have been 13 cases each of infective encephalitis and erysipelas, 2 cases of malaria and one case each of lead poisoning and typhus (marine). (See Table VII.VIII). Twelve of the infective encephalitis cases died (92^{0}/o) and all the other cases apparently recovered.

SECTION VIII

THE CITY HOSPITAL FOR INFECTIOUS DISEASES

This hospital was established in 1899 and can provide accommodation for 449 patients.

Admission and isolation of certain cases of communicable disease (not only Notifiable diseases) is by arrangement with the hospital authorities.

There are 15 wards which are situated in pleasant lawned grounds close to the centre of the City and adjacent to the Somerset Hospital.

Practical training of medical students and nurses as part of their curriculum, takes place, and Registrars from the Departments of Medicine and Paediatrics of the University of Cape Town Medical School serve three month periods of rotation at the Hospital.

ADMISSIONS AND OCCUPANCY

The daily average number of beds occupied during 1976 is given for various diseases in Table VIII.I. The average daily number of patients in the hospital was 243 of whom an average of 198 were municipal residents and 45 were from outside the Municipal area.

Of the average daily number of local patients, 2,6^{0}/o were White and the rest of other races, whereas of the average daily number of non-resident patients, 11,53^{0}/o were White, reflecting the Regional nature of this hospital.

White infectious disease cases from the whole Western Cape are admitted but patients of other races are admitted from a smaller area because there are other facilities for them (e.g. Worcester and Stellenbosch).

Admissions, discharges and deaths are detailed by race and sex in Table VIII.II.

Of the total of 2 009 patients either in hospital at the beginning of the year or admitted during the year, some 3,2^{0}/o (65 patients) died during the year, 87,2^{0}/o (1 751 patients) were discharged and 9,6^{0}/o (193) remained in hospital at the end of the year.

The age distribution of these 2 009 patients are detailed by race in Table VIII.III – nearly 60^{0}/o were aged less than 5 years.

EPIDEMIOLOGICAL DESCRIPTION OF CERTAIN DISEASES

Pulmonary Tuberculosis

Whites of both sexes and any age are admitted to the City Hospital but only young children and female adults of other race groups (older children and males of other races being provided for at the Brooklyn Chest Hospital). This admission policy affects the age- race - sex distribution of admitted patients as illustrated in Figure 8.1 (and see Table VIII.IV); nevertheless this figure shows how much more affected are white males than females and how there is a rise in number of admissions with a rise in age of these White males. In contrast Coloured and Black female adult admissions are highest in the 15 to 34 years age group and fall off sharply with increasing age. These facts should be interpreted in the light of the demographic data contained in Figure 3.2 but it is probably true that the White data reflects the ever diminishing incidence of this disease over the past few decades while the Coloured and Black data reflects the vulnerability of females in their most fertile years.

There was no obvious seasonal trend to admissions and deaths (Figure 8.2). An average of 52 patients were admitted each month and deaths amounted to 3,3^{0}/o of admissions.

36 infants or toddlers were admitted as contacts of their mothers.

TUBERCULOUS MENINGITIS

The same admission policy concerning age and race of patients applies as far as Pulmonary Tuberculosis.

Figure: 8.1 *ADMISSION TO THE CITY HOSPITAL OF WHITE, COLOURED AND BLACK PATIENTS WITH PULMONARY TUBERCULOSIS, BY SEX AND AGE-GROUPS: 1976*

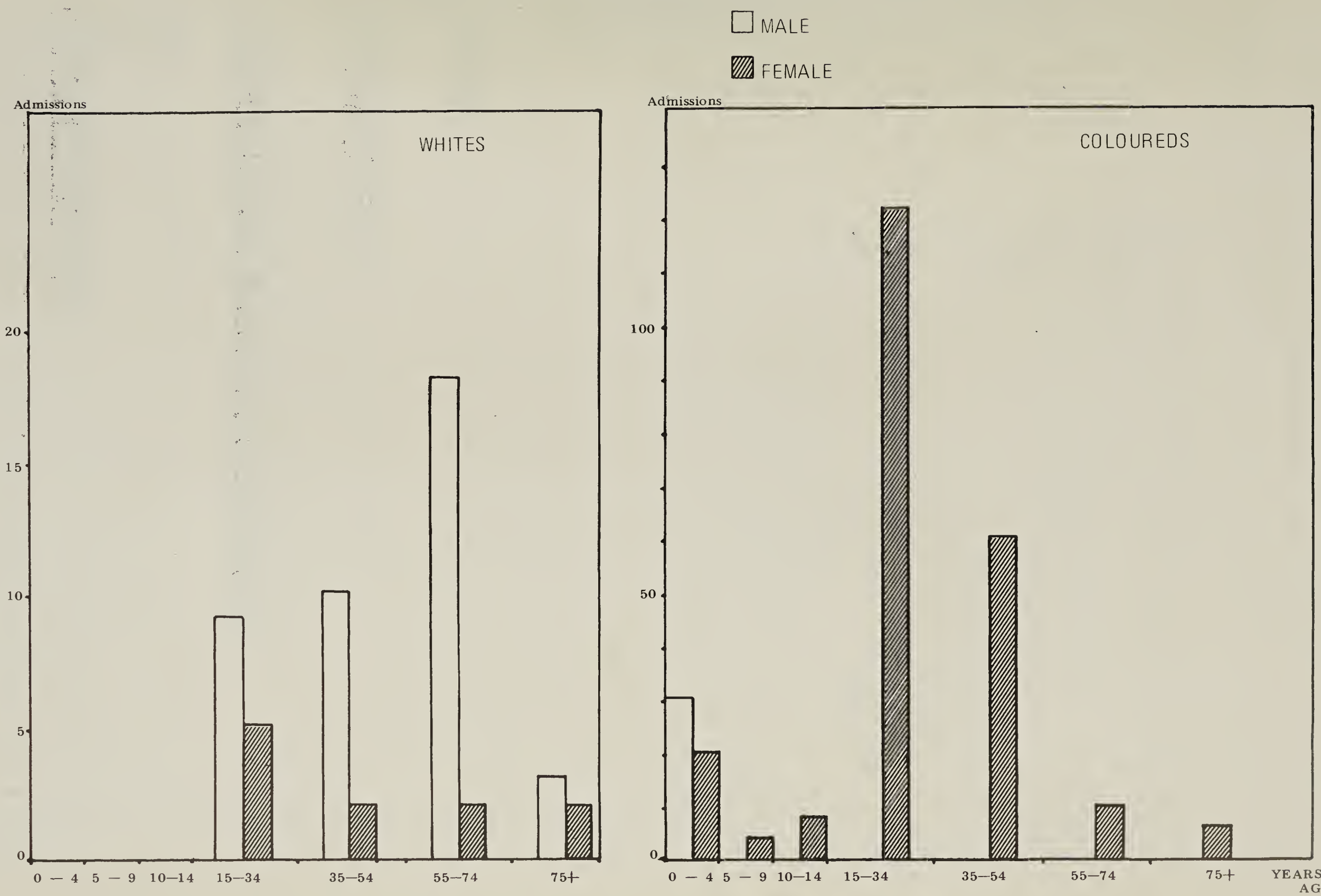


Figure: 8.1

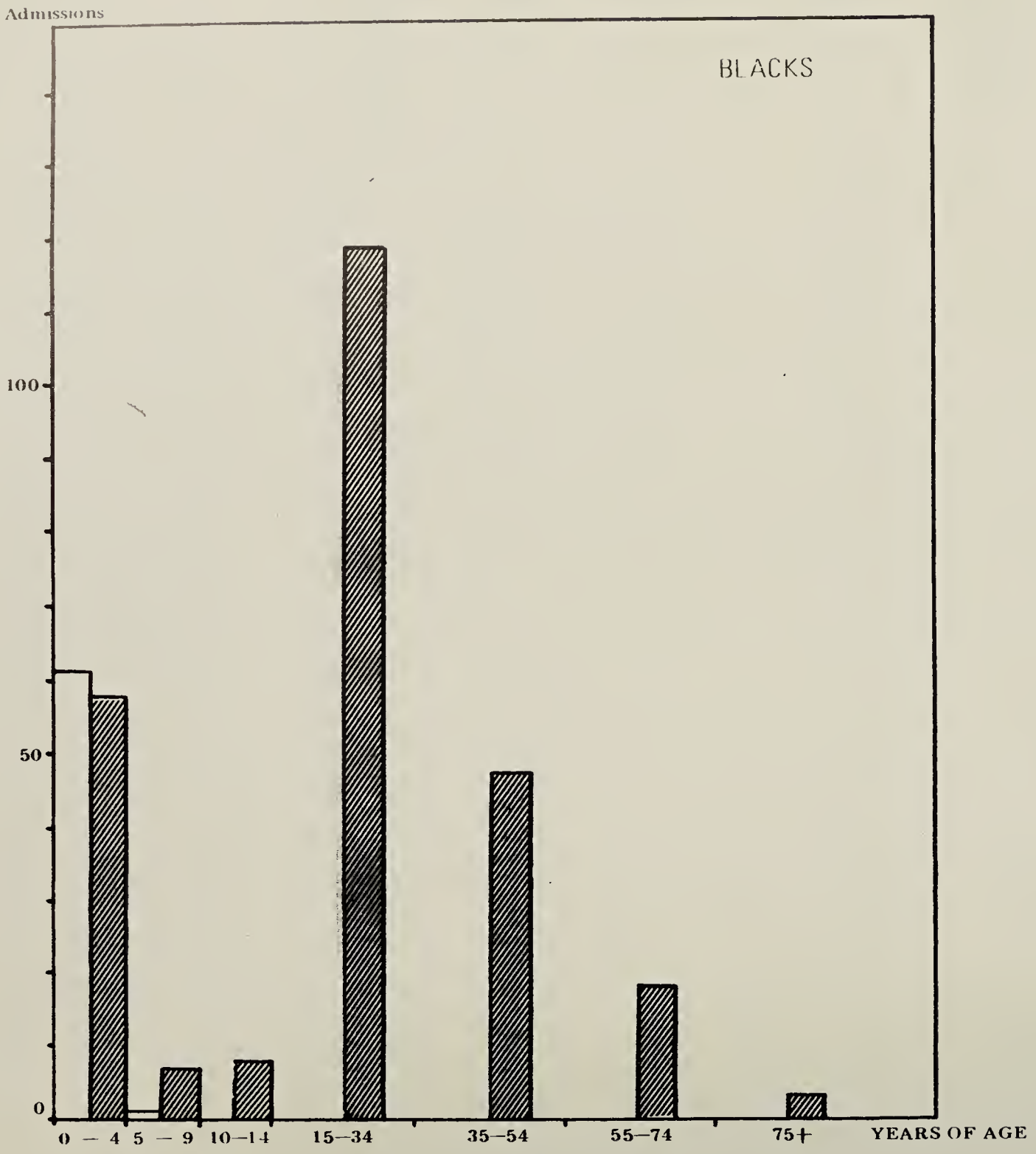


Figure: 8.2 *PULMONARY TUBERCULOSIS PATIENTS DYING AT, OR ADMITTED TO, THE CITY HOSPITAL BY MONTH OF ADMISSION: 1976*

There were 12 Coloured and 11 Black admissions (see Table VIII.V) with no obvious seasonal trend although half the cases were admitted over the May/June/July period.

Of these cases 17 were Cape Town residents of whom 6 had records of having received BCG. (4 in 1975 and 2 in 1972).

Measles

The severe toll taken by this childhood disease is revealed in Tables VIII.VI a) and b). Most cases were aged less than two years (see Figures 8.3 and 8.4).

The seasonal pattern of admissions is illustrated in Figure 8.5 and it is of interest that the Black group peaked first, followed by the Coloured and later by the White groups.

The figures include out of City cases and so cannot be converted to incidence rates as the population served is not defined in this report.

The mortality of admitted cases was 3,8^{0}/o in 1976. Of the 626 admissions 24 died. (14 Coloured and 10 Black) in 1976 compared with 27 in 1975 (Coloured and Black).

Cerebrospinal Fever

There were 216 cases of this disease admitted (see Tables VIII.VII a) and b)).

It is of interest that whereas Blacks accounted for 38^{0}/o and Coloureds for 60^{0}/o of measles admissions, Blacks accounted for only 11,6^{0}/o and Coloureds for 80^{0}/o of cerebro-spinal fever admissions. It is likely that this disparity is due to the fact that measles is more serious in Blacks because of nutritional and other socio-economic factors – whereas every case of cerebrospinal fever is life threatening, measles cases who are well nourished and have better home circumstances (as is more often the case with Coloured than with Black families) do not usually warrant admission. Figures 8.6 (all races) and 8.7 (Coloured only) illustrate the age – sex distribution of CSF admissions.

There was an increased number of admissions in late winter/spring (Figure 8.8).

Mortality was highest in Blacks at 4^{0}/o (1 death for 25 admissions), then Coloureds at 2,9^{0}/o (5 deaths for 172 admissions). There were no White deaths (18 admissions) or Asian deaths (1 admission).

Overall mortality of admitted cases was 2,8^{0}/o (NB: many cases die before admission and the mortality rate of local Notified cases is 19^{0}/o – see Section VII page 72).

Poliomyelitis

Admissions are tabulated in Tables VIII.VIII a) and b) and illustrated in Figure 8.9.

Coloureds accounted for 34 (81^{0}/o) of the 42 cases, the remainder being Black.

79^{0}/o of the cases were admitted in the six month period April to September.

The mortality was low at 2^{0}/o (1 death for 42 admissions).

Only six cases were local, the rest being resident in outlying areas.

Typhoid Fever

Twenty of the 30 admissions were Coloured (see Tables VIII.IX a) and b)); 9 Black cases and 1 White case were also admitted. There was no seasonal fluctuation.

The age distribution of cases is illustrated in Figure 8.9. Unlike poliomyelitis, which is also spread by the faecal-oral route, the cases admitted were older children or adults.

Figure: 8.3 *BLACK PATIENTS ADMITTED TO THE CITY HOSPITAL WITH MEASLES, BY SEX AND AGE-GROUP: 1976*

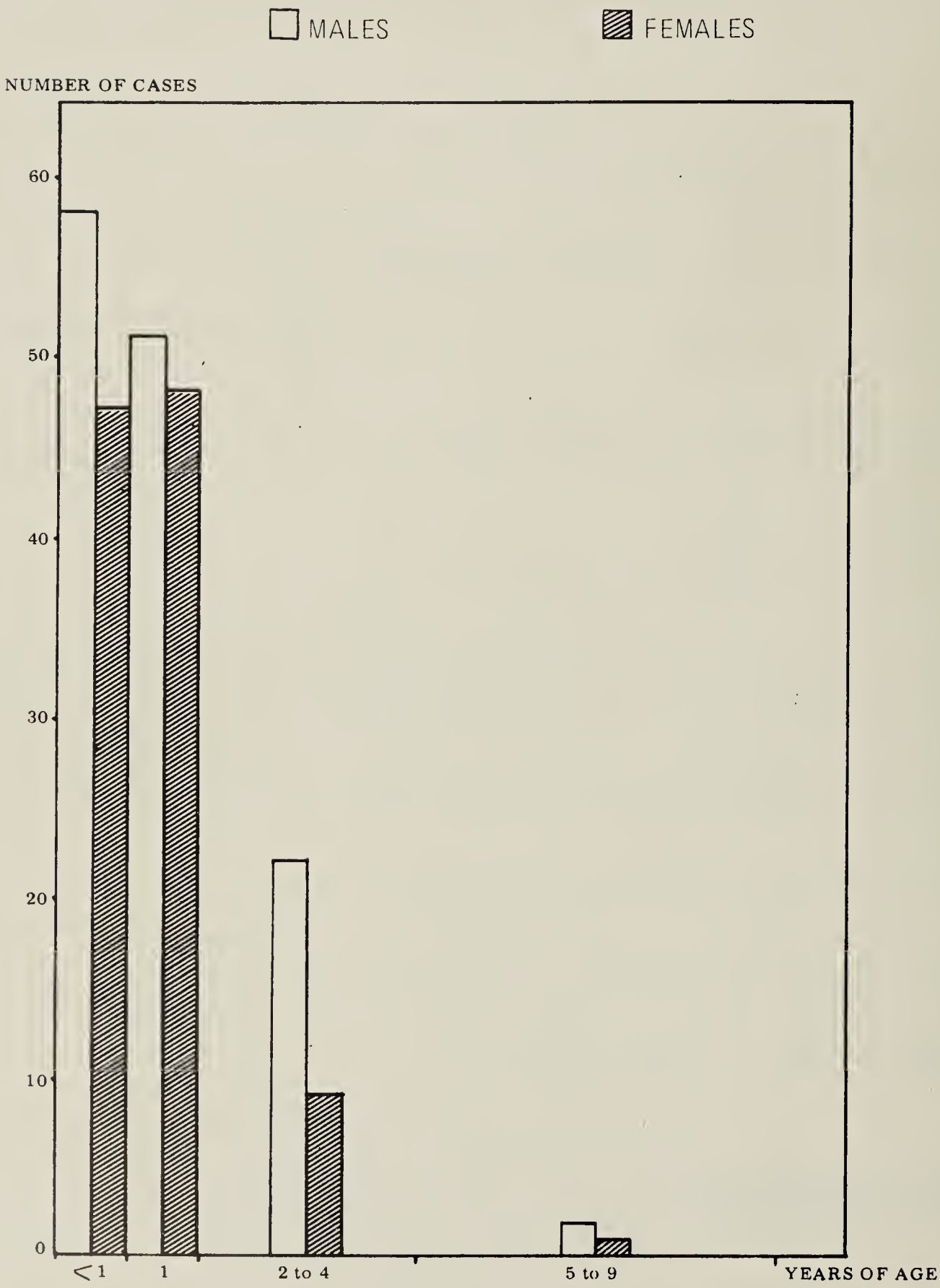


Figure: 8.4 *COLOURED PATIENTS ADMITTED TO THE CITY HOSPITAL WITH MEASLES, BY SEX AND AGE-GROUP: 1976*

Figure: 8.5

MEASLES ADMISSIONS TO THE CITY HOSPITAL BY RACE AND MONTH OF ADMISSION: 1976

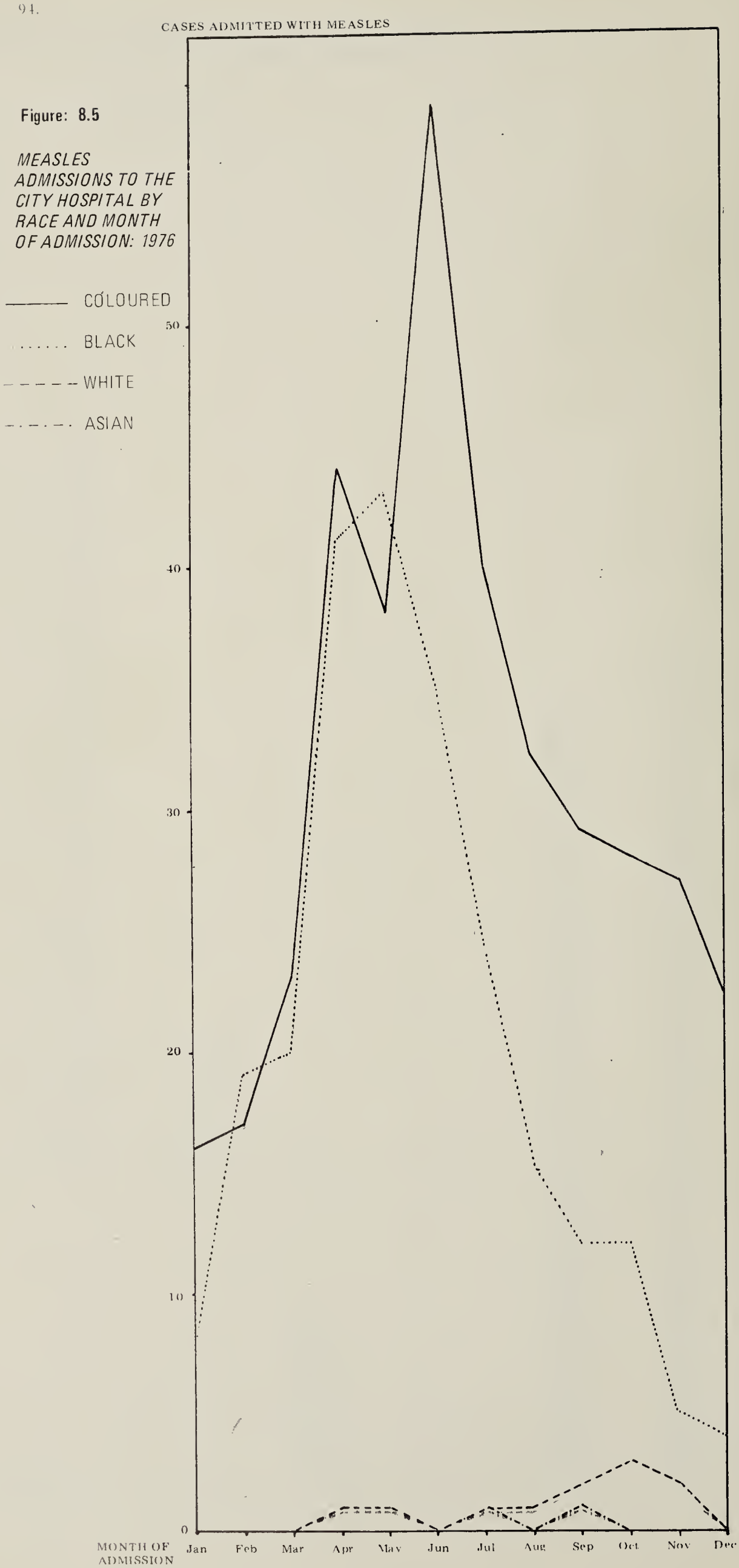


Figure: 8.6 *CASES OF CEREBRO-SPINAL FEVER ADMITTED TO THE CITY HOSPITAL BY SEX AND AGE-GROUP: 1976*

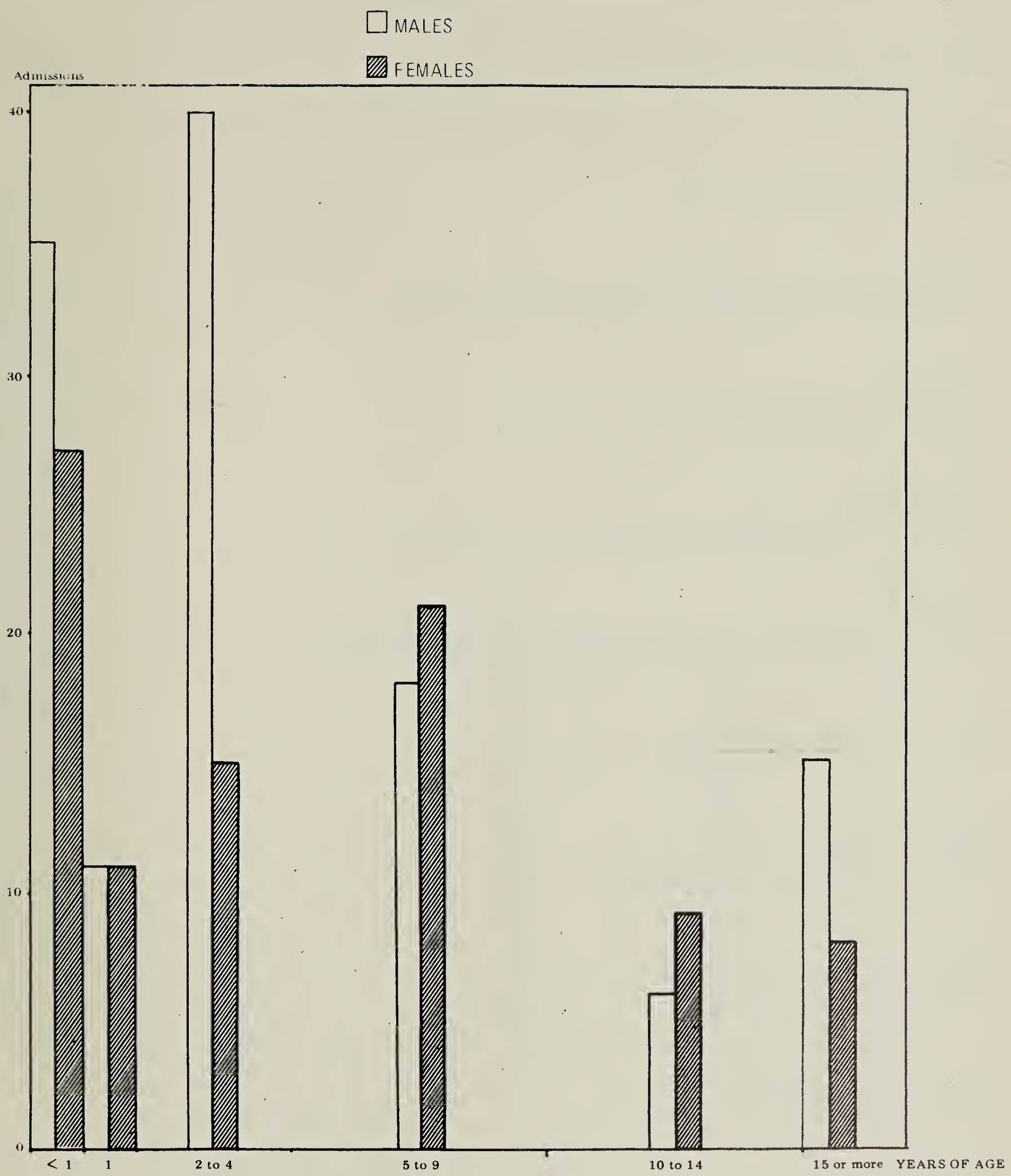


Figure: 8.7 *COLOURED CASES OF CEREBROSPINAL FEVER ADMITTED TO THE CITY HOSPITAL BY SEX AND AGE-GROUP: 1976*

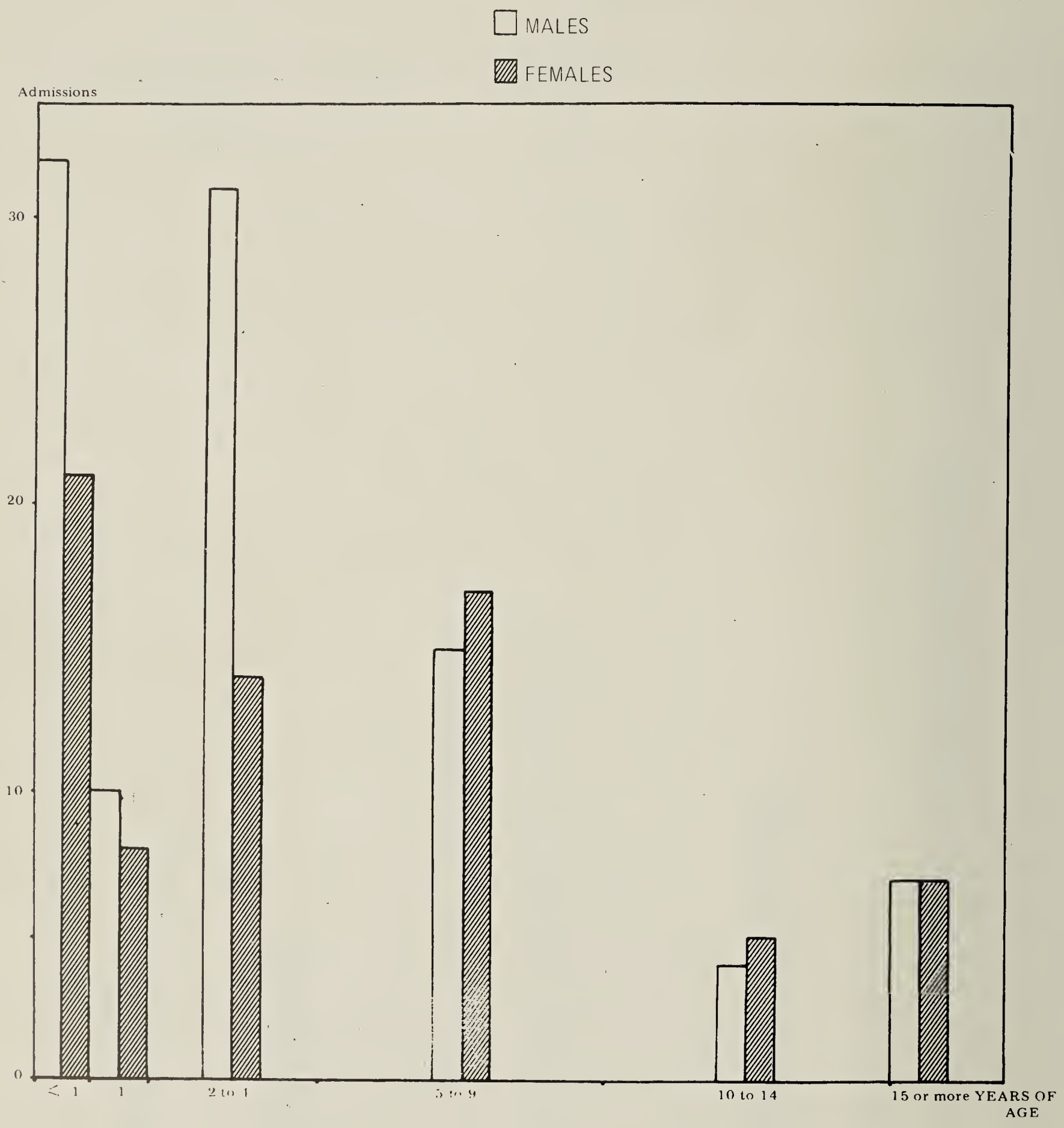


Figure: 8.8 *CASES OF CEREBROSPINAL FEVER ADMITTED TO THE CITY HOSPITAL BY RACE AND MONTH OF ADMISSION: 1976*

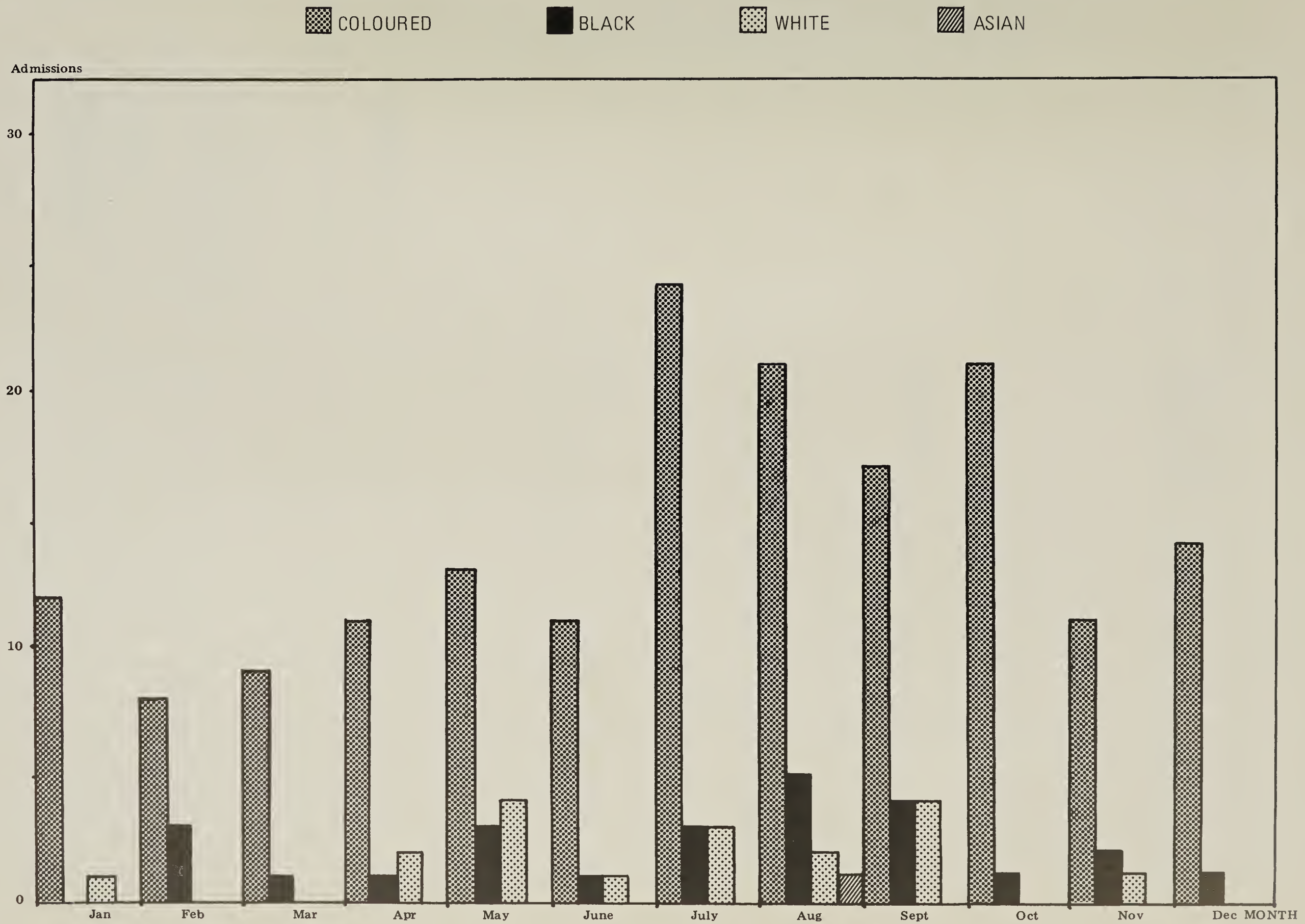


Figure: 8.9 *ADMISSIONS OF CASES OF TYPHOID AND ACUTE POLIOMYELITIS TO THE CITY HOSPITAL BY SEX AND AGE-GROUP: 1976*

Diphtheria

Tables VIII.X a) and b) detail admissions by age, race sex and month of admission. There were 11 Coloured and 2 Black cases.

Seventy per cent (9 out of 13 admissions) of cases were admitted in the spring/early summer months of September, October, November.

There was one death (7,7%).

Whooping Cough

Table VIII.XIa) and b) detail admissions by age, race sex and month of admission. There were 28 Coloured (72%), 7 Black (18%) and 4 White (10%) admissions. Two thirds (26) were aged under one year. There were few cases in mid-winter.

The one death represented a mortality of 2,6%.

CLINICAL ROOM AND X-RAY DEPARTMENT

This Department is used for special procedures in regard to in-patients and out-patients and to staff.

Attendances and procedures are detailed in Table VIII.XII.

The surgical consultations refer to the panel of thoracic surgeons and representatives of the two Tuberculosis hospitals in Metropolitan Cape Town, who assess cases for surgery.

The Dental Officer of the City Health Department attends periodically and provided treatment for 74 patients during the year.

AMBULANCE AND DISINFECTING STATION

This is situated in the grounds of the City Hospital, Portswood Road. There is garage accommodation, in which are housed (besides other departmental cars) three ambulances for the removal of cases of infectious diseases, two vans for the transport of infectious and disinfected bedding, and two vans for the distribution of supplies to the municipal clinics.

The disinfecting station contains two Washington-Lyon pressure steam disinfectors and a formalin fumigating chamber.

The ambulance and disinfecting service is staffed by the ambulance officer, disinfection officer, five motor drivers and two labourers.

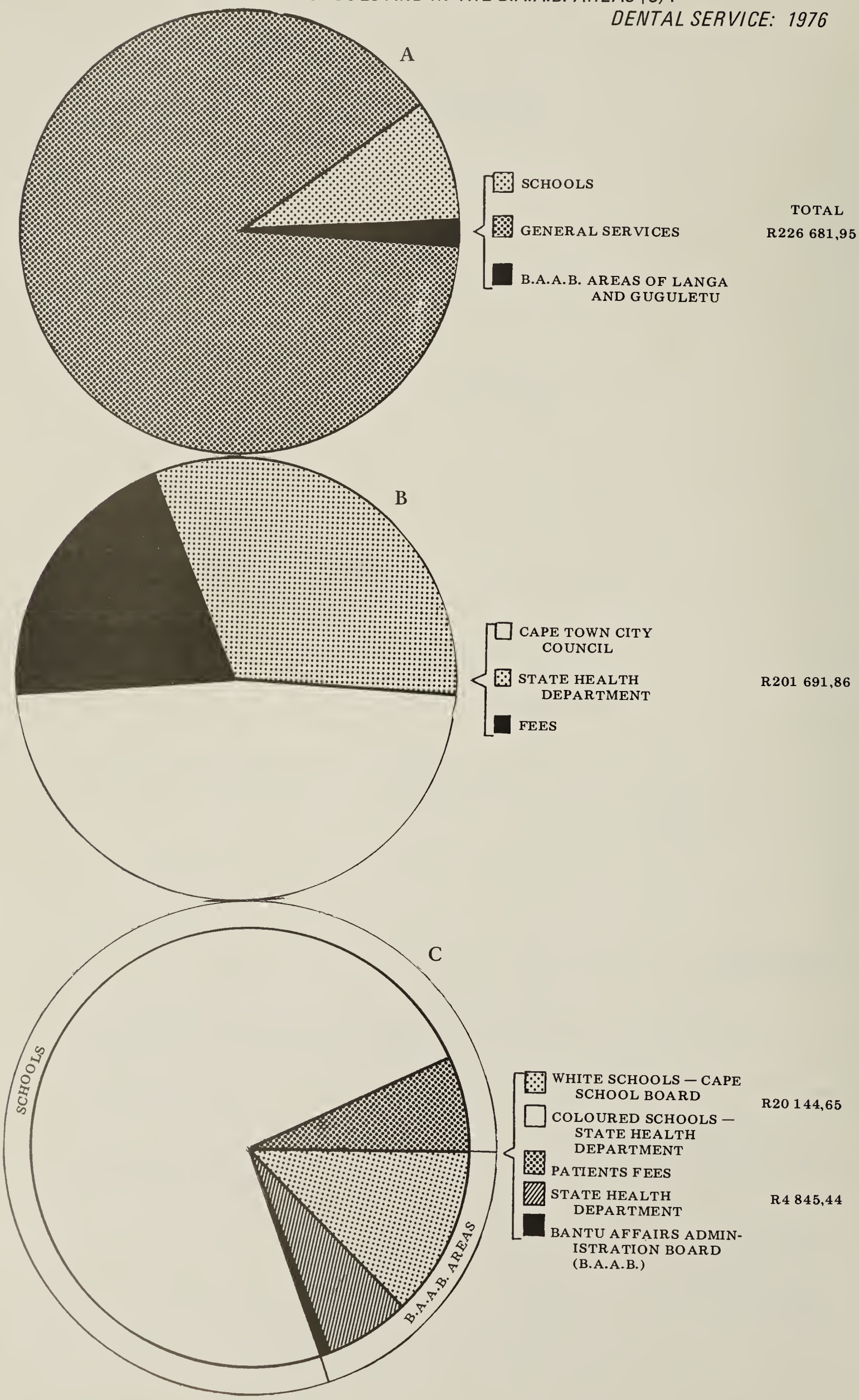
This staff is also responsible for the disinfecting of houses and other premises for infectious diseases and other conditions. A fitter, assisted by a boiler attendant and labourer, is in charge of the disinfection station.

(The general ambulance service for the Cape Peninsula is operated by the Town Clerk on behalf of the Cape Provincial Administration).

The infectious disease ambulances conveyed 2 888 patients over a total of 71 276 km, being 1 814 return trips from the City Hospital and back and 666 trips from the City Hospital to transfer patients from other hospitals to other hospitals or premises.

The vans covered 80 396 Km during the year and other vehicles did 145 656 Km.

Figure: 9.1 *EXPENDITURE (A); AND INCOME FROM GENERAL SERVICES (B) AND FOR SERVICES AT SCHOOLS AND IN THE B.A.A.B. AREAS (C) : DENTAL SERVICE: 1976*



SECTION IX

DENTAL SERVICE

THE NATURE OF THE SERVICE AND ITS FINANCING

The dental service operated by the City Health Department for many years to the undoubted benefit of Municipal residents has a number of different facets; it is both a subsidised indigent service for all races and a refundable school service for Whites and Coloureds.

Total expenditure on the service in 1976 amounted to R226 681 which is illustrated in Figure 9.1 a) b) and c) as to the source of income and the destination of the finance.

There are no fees levied on patients making use of the refundable school service, as the dental care of these White and Coloured children is the statutory responsibility of the Provincial Administration and the State Health Department respectively and costs are fully refunded by these bodies. The service to Coloured schoolchildren is gradually being taken over by the State Health dental service as this newly formed body expands and is able to cope with the workload.

Patients availing themselves of the subsidised indigent service are expected to pay fees in accordance with their income and a fully qualified Social Worker is responsible for assessing the level of indigency in every case. The revenue obtained from patients over the period 1973 to 1976 is detailed in Table IX.I in relation to new and total attendances and the number of sessions. In 1976 the revenue per new patient averaged R2,39; per attendance averaged R1,17 and per session averaged R18,53.

THE WORKLOAD ON THE DENTAL SERVICE

The work performed at the nine Council dental clinics and at two local hospitals during the year is summarised in Table IX.II.

Trends over the years 1974, 1975 and 1976 in new and total attendances are detailed in Table IX.III and illustrated in Figures 9.2 and 9.3.

Overall total attendances fell by 19,6^{0}/o from 1974 to 1975 and by 17,9^{0}/o from 1975 to 1976. These falls can largely be ascribed to the gradual takeover by the State Health Department of the Coloured school child service, and to the civil unrest in 1976. It is significant to note that if attendances at Langa and Guguletu and at clinics for school children elsewhere are excluded from consideration (see Table IX.IV and IX.V) then the remaining attendance totals showed a slight increase in 1976 compared with 1975, which is illustrated in Figure 9.4.

The expansion of the State dental service has relieved the Council dental service of a considerable amount of work involved in treating Coloured school children, the number of sessions for these patients decreasing by 12,2^{0}/o from 1974 and by 54,1^{0}/o from 1975 to 1976 while the total of such attendances fell by 28^{0}/o from 1974 to 1975 and by 50,1^{0}/o from 1975 to 1976 (see Figure 9.3).

Extractions have for years been performed under general anaesthesia but this method is becoming more expensive and alternatives are under review. There will, however, always be a group of very young children requiring extractions for whom general anaesthesia is indicated.

One result of the high extraction rate is a high demand for dental prostheses and in 1976 the direct cost of providing these amounted to R18 108 (of which R11 947 was refunded by the State Health Department and R6 169 was paid in fees by the patients).

There is little likelihood that the overall picture of dental health in Cape Town which is extremely bad in the Coloured group can be significantly improved without fluoridation of the water supplies. It is devoutly to be hoped that State Health Department will make this a cornerstone of their new Dental Health Policy in so far as Cape Town is concerned.

Figure: 9.2 *WHITE ATTENDANCES AT DENTAL CLINICS (IN HUNDREDS OF PERSONS)*

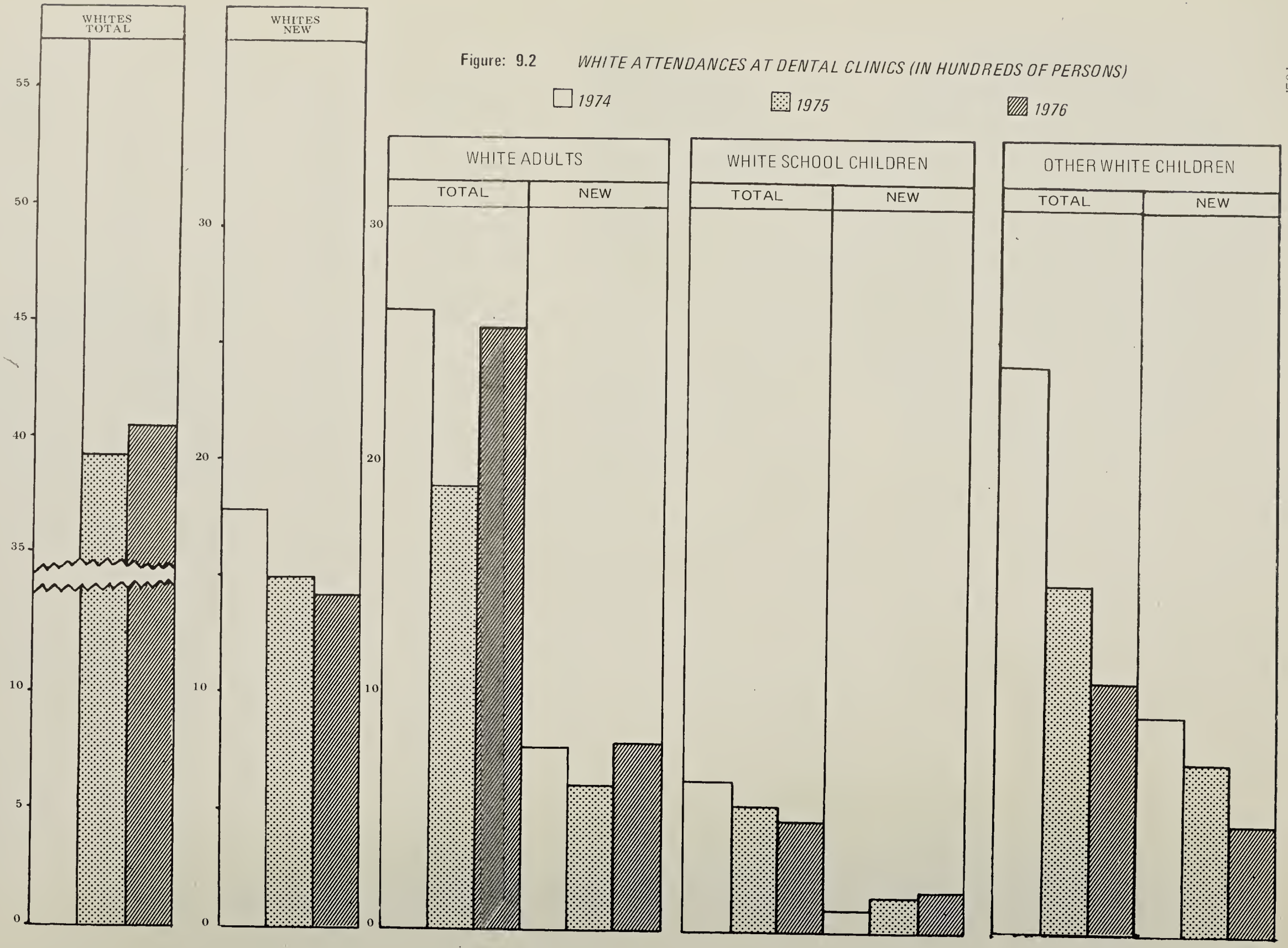
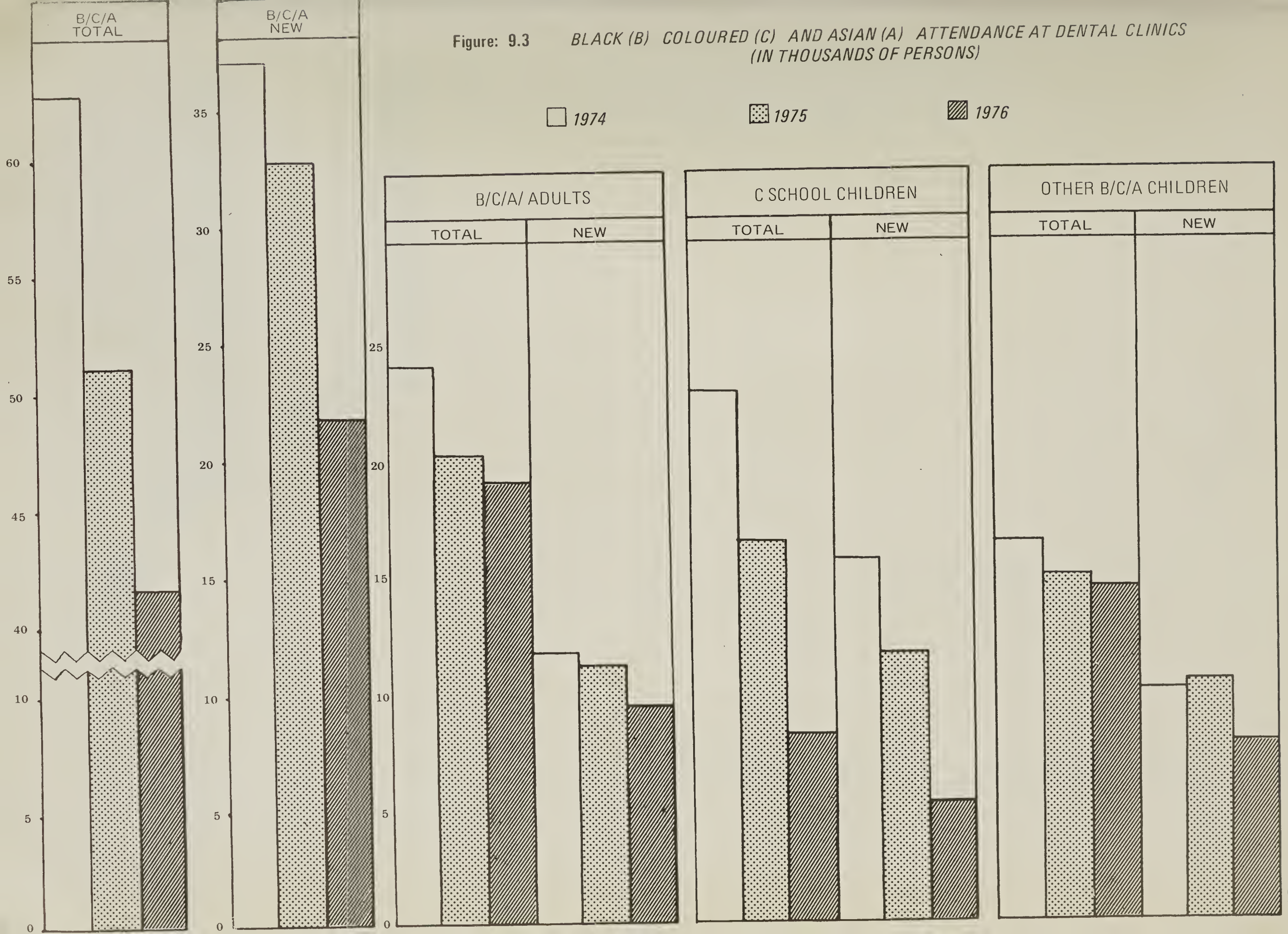


Figure: 9.3 *BLACK (B) COLOURED (C) AND ASIAN (A) ATTENDANCE AT DENTAL CLINICS (IN THOUSANDS OF PERSONS)*



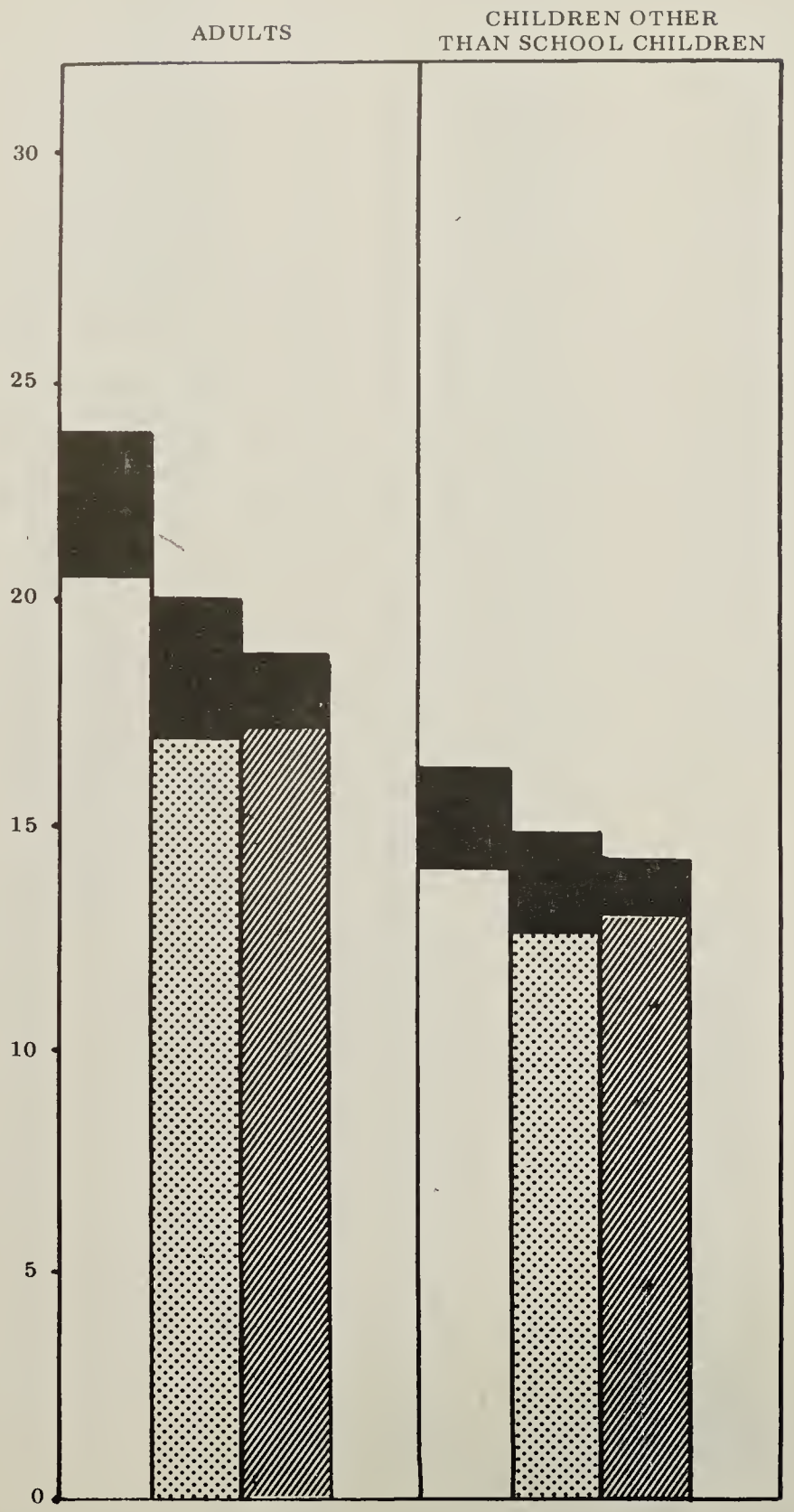


Figure: 9.4 *BLACK, COLOURED AND ASIAN ATTENDANCES AT DENTAL CLINICS (IN THOUSANDS) SHOWING THE EFFECT OF THE CLOSURE OF LANGA AND GUGULETU:*

1974

1975

1976

ATTENDANCES AT LANGA AND GUGULETU CLINICS IN THE YEAR OF THE COLUMN SHOWN

SECTION X

OTHER SERVICES

DOMICILIARY MEDICAL SERVICES

The City Council provides medical attention in their homes for indigent sick persons needing such service. During 1976 the work was carried out by medical practitioners with the co-operation of the District Nursing Organisation of the Cape Provincial Administration. Arrangements for the supply of medicines etc. are made with local chemists.

In addition, applications are received from persons seeking assistance to purchase spectacles under poor relief regulations.

One half of the cost of medical attention and the full cost of surgical appliances and spectacles are refunded to the Council by the State.

During the year, 197 applications for free medical attention and 5954 applications for spectacles were received. The sum of R17 708,85 was collected towards the cost to the Council of R99 189,26, for spectacles.

FREE BURIALS

The Public Health Act places upon the local authority the responsibility for the removal and burial of the body of any destitute person, or any dead body which is unclaimed or of which no responsible person undertakes the burial. The cost falls upon the local authority, although it may be legally recovered. Each year a contract is given out to an undertaker to carry out this work for the council. In the year the number of such burials was 252.

MUNICIPAL WASHHOUSES

There were 4 washhouses in the municipal area namely at Hout Street Mowbray, Claremont and Wynberg.

Council closed down the washhouse at Hout Street from 1976–02–27.

Mowbray, Claremont and Wynberg washhouses were closed down from 1976–10–29.

The attendances and takings at the washhouses (including ironing rooms) during the year are given in Table X.I.

The attendances at the washhouses show a considerable decrease, a trend that has become apparent over the last few years.

This is due to the dying out of the older washerwomen, the increase in flat dwellers who take their laundry to the laundrettes, which are opening up all over the municipal area and the ever increasing number of households with washing machines.

MEDICAL EXAMINATIONS

Medical examinations for initial entry into the Council service and for admission to the municipal pension fund are carried out by the department. During the year 3573 attendances were recorded as on Table X.II. The Department also provides medical attention for Fire Brigade and Traffic personnel.

CLEANSING STATION

(SCABIES AND PEDICULOSIS)

The cleansing station at 15 Cowley Street, Cape Town, is provided for the disinfection of verminous persons and their clothing. It is in the charge of a clinic assistant, who works under the supervision of a medical officer and has two assistants. The work consists mainly of the treatment of scabies, pediculosis and impetigo.

The attendances in the year under report were as in Table X.III.

The Cleansing Station only covers the local area of District Six, Woodstock, Salt River and Observatory, but scabies is also treated where necessary at the child welfare centres in other areas. Plans are afoot to provide a second cleansing station in Athlone.

SECTION XI

ENVIRONMENTAL HEALTH

1. HEALTH INSPECTION

Control over the quality of the environment has always been a major function of local authorities. In a large city such as Cape Town the problems posed by such a concentration of people needing clean air, pure water, sound food, comfortable housing and freedom from environmental or occupational hazards are multiplied by the biological and industrial wastes produced by them.

The Medical Officer of Health is obliged in terms of the Public Health Act to, inter alia, keep himself properly informed as to public health and sanitary circumstances in his district and to make such inspections and enquiries as may be necessary for this purpose. It is clearly a physical impossibility for an individual to do this in person and the Public Health Act makes provision for the appointment of sanitary (Health) Inspectors who function as the eyes and ears of the Medical Officer of Health and enforce his decisions.

The Health Inspectorate staff of the City Health Department is detailed in Section 1 from where it will be seen that there are five Divisional Health Inspectors each controlling a geographic segment of the Municipal area from offices within that area. Within these divisions the establishment of comprehensive Community Health Centres has allowed for the posting of Health Inspectors closer to their field of operations and has allowed for a more wholistic approach to health care. With the expansion of the Health District/ Community Health Centre concept there will inevitably be some reorganisation of the existing divisional boundaries. At present there are Divisional offices at Libertas (2 divisions), Woodstock, Rondebosch and Wynberg with individual inspector's offices at Silvertown, Retreat, Kensington, Athlone Central, Bonteheuwel and Newfields.

From their title it is to be expected that Health Inspectors inspect as a major part of their work. The inspections and other work carried out on district during 1972–1976 are tabulated in Table XI.I. The lower total number of visits is related to the freezing of certain vacant posts during the year as part of the economy drive.

Action taken in respect of the above inspections is tabulated in Table XI.II, the total number of notices served in 1976 being 1 610, (items which were included thereon being detailed in Table XI.III).

Apart from general responsibility for environmental health and the control of staff in their Divisions, the Divisional Health Inspectors are responsible for food sampling in their area in terms of the Foodstuffs, Cosmetics and Disinfectants Act, Act No. 54 of 1972 (see page 117).

The Health Inspectorate is also involved in water sampling, the implementation of the Municipal food handling regulations (including meat and butchers' vehicle control and the control of food at the Market); the inspection of housing for purposes of the Housing and Slums Acts, the supervision of public sanitary conveniences and the inspection of" premises under the offensive Trades Regulation and the Registration and Licensing of Businesses Ordinance."

Air Pollution Control, Milk Control and Pest Control are entrusted to specialised Health Department staff; the abattoir is under the control of the Town Clerk and the Director of the Abattoir; Drainage, Sewerage and Refuse Removal are functions of the City Engineers Department; Housing falls under the Town Clerk.

All these aspects of environmental health are discussed in the following sections.

While every effort is made to health educate the public and to persuade offenders to rectify matters it is sometimes necessary to resort to legal proceedings, a record of which is summarised in Table XI.IV.

2. AIR POLLUTION

The register of premises using fuel-burning appliances in processing, air conditioning, space-heating, or water-heating continues to grow. New industry or buildings are partly responsible for this growth by existing industry or other premises are still being found which have not been previously registered. There are now five hundred and one premises operating nine hundred and seventy-eight appliances. This represents an increase of fifty-two premises and seventy-nine appliances.

This list does not include any dwellings since they are dealt with separately under the Smoke Control Zone Orders. Table XI.V details approved installation of fuel burning appliances in 1976. Table XI.VI details inspections carried out during 1976.

COMPLAINTS

One hundred and twenty-four complaints were dealt with during the year under review, nine of which were written and the rest verbal or telephonic (see Table XI.VII).

Most were resolved with a single visit. Others were not so easily resolved and required several visits. A few were more complex and necessitated protracted negotiations with managements to arrive at the best practicable solutions.

Some of the most difficult complaints to rectify are caused by odours, fumes or dusts which are not the products of combustion. Legislation to deal with these nuisances is not easy to apply, and in some cases cannot be applied at all. These shortcomings in the legislation are recognised by Local Authorities and the State but it is not proposed to make changes until the economic climate improves.

EXCESSIVE SMOKE EMISSION

One hundred and two instances of excessive smoke emission were dealt with, meaning that the smoke was in excess of that which the plant is capable of producing under normal operation. Most were caused by mal-operation, poor maintenance or break-down.

A few were the result of difficulties experienced with a different intake of oil or problems associated with the inferior coal now being supplied to industry. Both these sets of problems are due to changes in fuel specifications as a result of the so – called fuel crisis and the effort to make more use of a barrel of crude oil or the ton of coal as mined. This means, in effect, that fuel-burning-appliances need more supervision than before and a higher quality of manpower.

NOTICES SERVED

Burning of Waste Material continues to occupy far too much of the Smoke Inspector's time. Seventy-four notices were issued to offenders – these being the more serious contraventions of the regulation. Forty-seven of these were as a result of complaints received. The others were observed by staff.

Unofficial Installations. Forty-five notices were issued for unofficial installations. This figure is unusually high and is the result of several installations being discovered as being done by one firm. The local manager was quite prepared to ignore the regulations, in spite of repeated approaches by the air pollution control staff. Eventually an approach was made to the board of directors of the company concerned which resulted in a complete list of installations done over the last three years. Most were unofficial. Hopefully this firm will now toe the line.

Smoke and Soot Nuisances. Three notices were served under this heading. All were concerned with light-oil-fired boilers on the ground floor of a multi-storey building. It may be necessary to refuse this type of installation in future on the grounds that nuisance results, far too often, from the lengthy and sometimes tortuous flue system required.

Notices of Intention to Prosecute. This procedure is only adopted when all other approaches have failed to produce results and court action is deemed the only solution. Five such notices were issued. Three of these produced the required action.

Court Cases. Two court cases were prepared and submitted to the Prosecutor. One resulted in a court action

Monitoring Air Pollution

in which the offender was found "not guilty", because of a supposed technical fault. In fact the tape-recording of the case revealed that the technical point did not exist and we could have appealed with the certainty that the decision would have been reversed. In the meantime the necessary work had been done and it was felt that nothing could be gained by pursuing the matter.

The second case was withdrawn by the public prosecutor at the last moment because the work required had been done.

INCINERATION

The central incineration plants planned for both the Cape Hospitals and the South African Railways and Harbours complex have been shelved due to the economic situation.

SMOKELESS ZONES

The first Smoke Zone Order became effective on 1976–02–14. To the end of the year only three visits involving smoke had been necessary.

The second Zone becomes effective on 1977–01–02.

CONFERENCE, SEMINARS, MEETINGS

The Air Pollution Control Officer attended the international conference held in Pretoria.

The staff attended a Smoke Control Officer's meeting in Stellenbosch.

Lectures and discussion groups were attended on measurement, silencing and exhaust of diesel engines.

These opportunities for discussion and exchange of information and experience are much appreciated and enable the staff to keep abreast of developments.

DIESEL VEHICLE SMOKE CONTROL

At a meeting with the Town Clerk, City Engineer and City Treasurer it was agreed that:

(1) Closer involvement by air pollution control staff in measurement of pollutants would be undertaken as an alternative to the Medical Officer of Health taking over this function and setting up what could be considered to be duplication of services. Monthly meetings now take place, between Chemical Branch and Air Pollution Control Branch, at which policy, finance and practice may be discussed.

(2) The Medical Officer of Health was given a mandate to discuss the transfer of Diesel Smoke Control from Traffic Department to Health Department in order to meet the wishes of State Health in co-ordinating vehicle pollution control, and also to release much-needed traffic officers for their primary function.

Unfortunately the staff position in the Branch has not allowed these negotiations to take place.

OPEN FIRES IN DWELLING HOUSES

Experiments were undertaken to establish whether smokeless fuels i.e. anthracite and coke, would burn successfully in unmodified household grates.

The fires were very difficult to establish without making smoke. The coke fire was self-sustaining once temperature had been reached but a large fire had to be maintained.

The anthracite fire was not at all successful.

The conclusion reached was that most fireplaces would not burn either fuel satisfactorily without some modification.

MEASUREMENT

Smoke and Sulphur Dioxide

The graphs of monthly averages at each of the established seven measuring stations for Sulphur Dioxide (SO_2), Soiling Index (Smoke) and Dustfall are included. Sulphur Dioxide measured in microgrammes per cubic metre, Soiling Index in SI units and Dustfall in grammes per square decametre. To transpose the SI units into the better-known international units of microgrammes per cubic metre an approximate factor of 3 may be applied. (i.e. 100 SI units = $\pm$ 300,ug/m^3).

Graphs of annual averages, summating all stations, for the period 1967 to 1976 are included. The downward trend for the three graphs is continued. Improvement has been noted visibly in the density of smogs occurring in the area. The number of occasions that smog occurs is entirely dependent on the weather, and varies little year by year. The density of the smog under these conditions is what the fight is all about.

The economic depression has severely curtailed the plans that South African Railways and Harbours, Hospital authorities and even some industrial polluters had made but it is still hoped that the downward trend can be maintained.

Apart from the reduction in the output of SO_2 from Table Bay Power station it is an established fact that the atmosphere has a much better capability to dissipate SO_2 if the visibles, or particulates, can be reduced.

Vehicle Emissions

The Nitrogen Oxides recorder had now produced meaningful results for more than 12 months. It would appear that on the occasions when poor atmosphere ventilation is present, or stable conditions exist,there is sufficient NO_x to assist the formation of photochemical smog. The instrument is now being modified to measure another of the constituents required for this process to see if that is also present in sufficient quantity.

It must be said that in spite of the campaign to use less petrol, and its higher price,the consumption of this fuel can only increase. This in turn means more emissions.

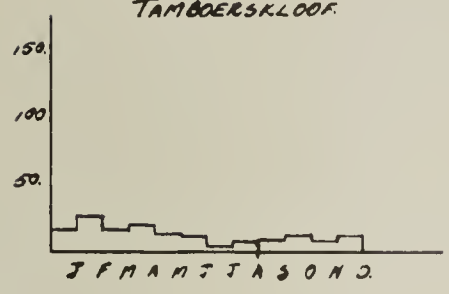
The C.S.I.R., however, in their report A.P.R.G. 76/6 indicate that South African cities do not need to take action in this regard as yet.

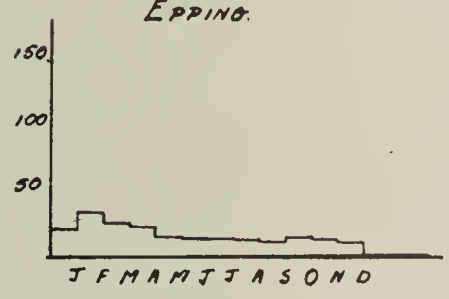
Overall Survey

The survey being undertaken by the University of Cape Town on behalf of the Council is making progress and an interim report on early results should be available to Council at the end of the summer 1976 – 7 period.

1976 Monthly Averages.

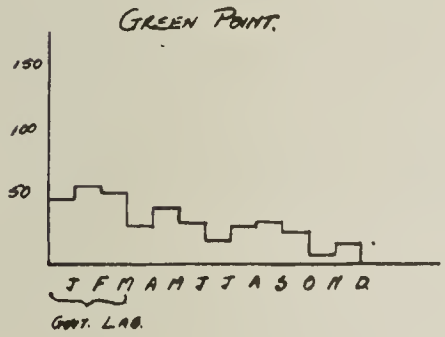
Sulphur Dioxide
SO_2 $\mu g/M^3$

Tamboerskloof.


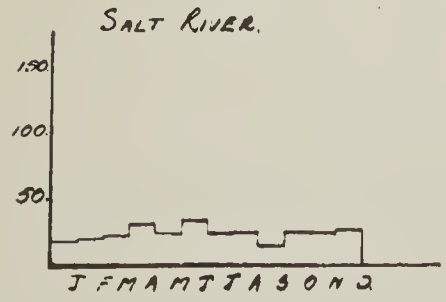
Epping.


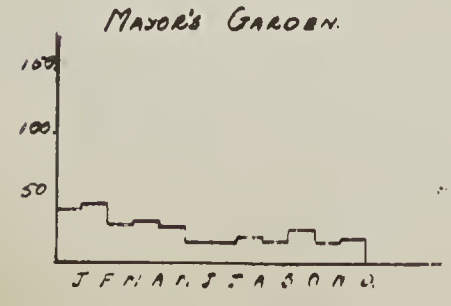
Foreshore.


* no reading.

Green Point.


Paaroen Eilano.


Salt River.


Mayor's Garden.


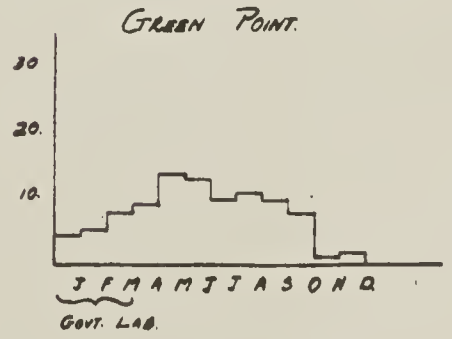
Soiling Index
S.I. units

Tamboerskloof.


Epping.


Foreshore.


* no reading.

Green Point.


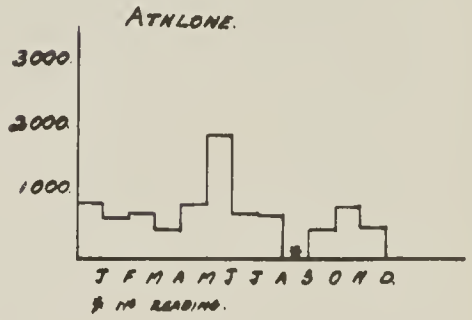
Paaroen Eilano.


Salt River.


Majors Garden.


Dustfall.
g/ decam^2.

Epping.


Atnlone.


* no reading.

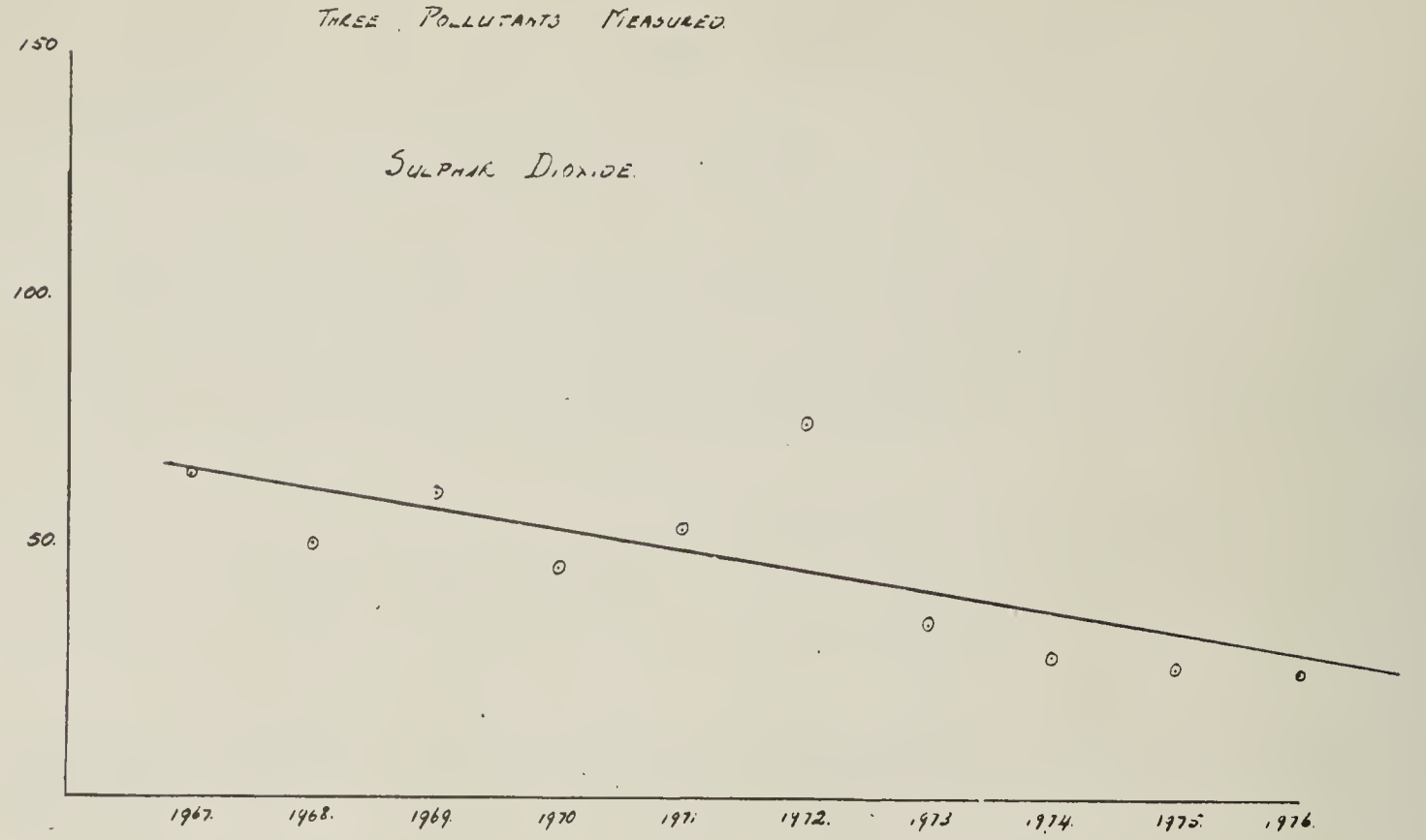
Green Point.

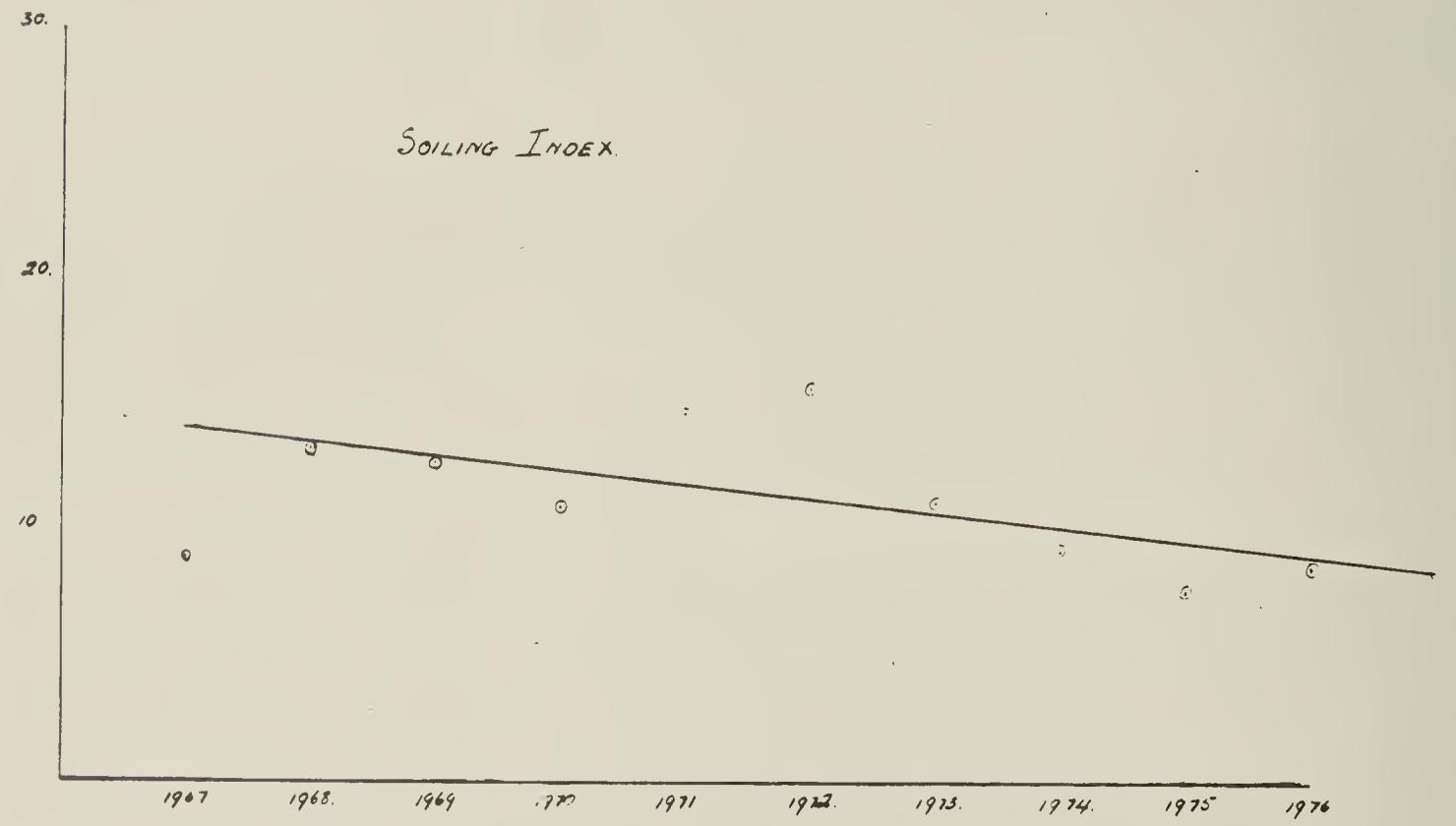

Paaroen Eilano.

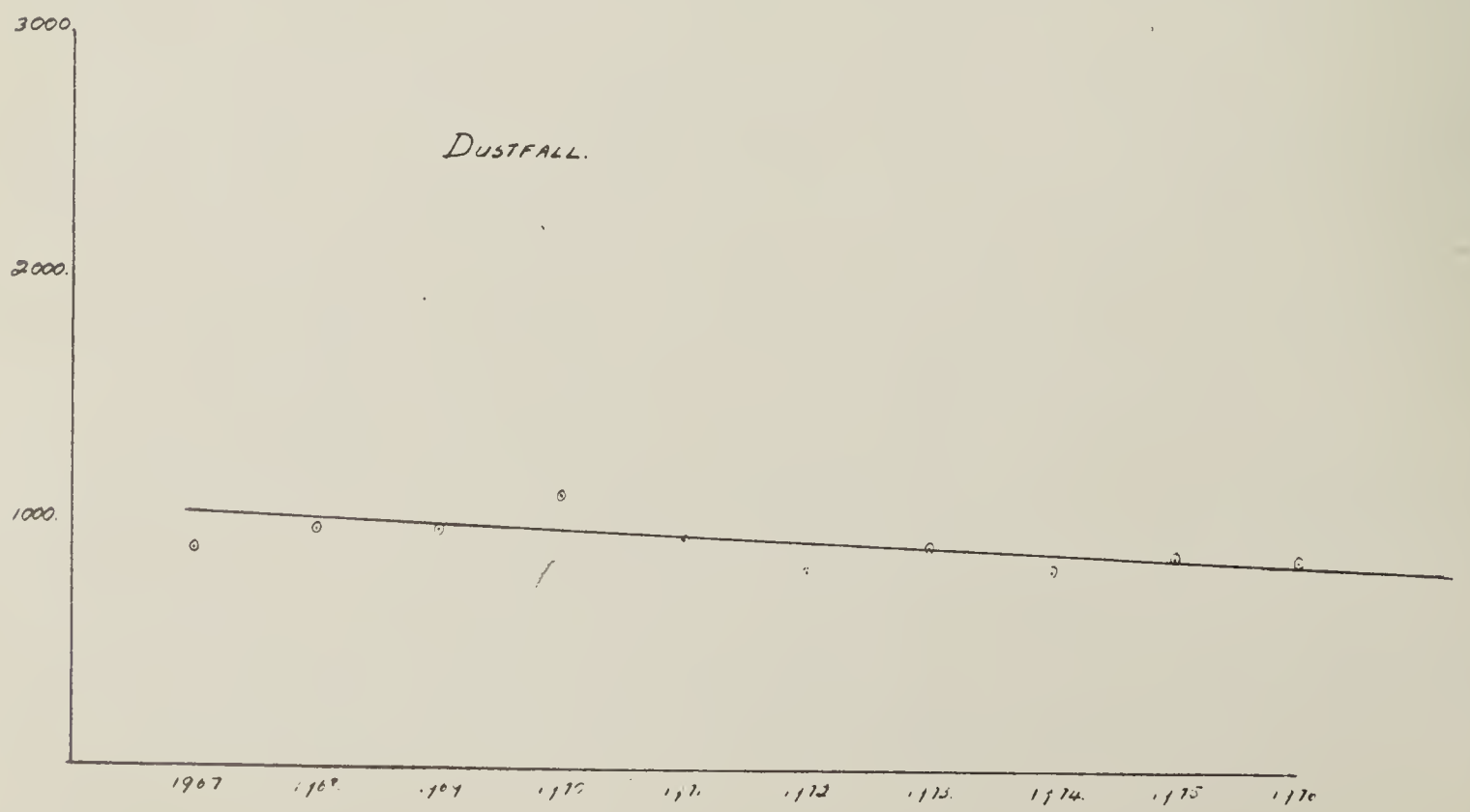

Salt River.


Mayor's Garden.


1967 - 1976 Annual Averages for the Three Pollutants Measured.







3. WATER SUPPLIES

The following are the main sources of supply:

Voëlvlei Dam	162 739	megalitres
Wemmershoek Dam	58 643	megalitres
Steenbras Dam	34 290	megalitres
5 Reservoirs on Table Mountain	2 377	megalitres

During 1976 the daily consumption varied between a maximum of 653 megalitres during the summer and a minimum of 195 megalitres during the winter. The average daily consumption during the year was 365 megalitres.

Samples of water are taken fortnightly at thirty-two different test points within the water reticulation system of the municipal area.

These samples are submitted to the State Pathological Laboratory for Bacteriological Report, and serve as a double check on the sampling carried out by the Chemical Branch of the City Engineer's Department.

Seventeen other dependant local authorities obtain their supplies of water from the Cape Town undertaking.

4. FOOD CONTROL

A. MILK SUPPLIES AND RELATED PRODUCTS

RAW MILK SUPPLIES

The City's milk shed comprises Vredenburg, Hopefield, Malmesbury, Paarl, Bellville, Stellenbosch, Wynberg, Cape, Worcester, Caledon, and Somerset West areas. A total of 190 producers were registered with the Council. They employed the following systems of milking:–

	% 1973	% 1974	% 1975	% 1976
Hand milking	38	29	20	18
"Round the line" and bucket milking	29	34	35	35
Parlours	33	37	45	47

It is a pre-requisite of this department that all producers supplying milk to Cape Town on a daily basis for fresh milk consumption make use of a refrigerated bulk tank. 3,2% still deliver in churns but to a powdered milk factory only. The raw milk is collected by insultated road tankers on a daily or alternate day basis and delivered to the pasteurising plants.

The shortage of milk experienced over the last few years has been replaced by a surplus. The average daily production was 348,073 litres (1975 – 336158) and the average daily consumption, i.e. total intake for fresh milk consumption, products etc. was 295764 litres (1975 – 299586). There was thus increased production and a drop in consumption.

INSPECTION AND LABORATORY CONTROL

RAW MILK

Milk samples are taken regularly by the Dairy Inspectors on the farms and during the year the following work was carried out:–
(Figures in brackets relate to 1975).

Total number of farm dairy inspections	1951	(2124)
Number of farms where major structural improvements were carried out	37	(41)
Number of herd inspections	251	(288)
Investigations on farms in connection with:		
(1) The unsatisfactory bacteriological control of milk	60	(95)
(2) incidence of Mastitis	23	(69)
(3) recording of temperatures of mechanically cooled milk	767	(723)
Number of unsatisfactory temperatures encountered	14	(2)
Number of samples brought to laboratory for analysis	1264	(957)
The following tests were carried out:		
Plate counts	1264	(957)
Eijkmann Test	1264	(957)
Laboratory Pasteurisation counts	1232	(953)
Mastitis Cell counts (D.M.C.)	1272	(952)

Test for inhibitory substances and the Brucellosis milk ring tests were done where necessary.

Road tanker milk is checked periodically and apart from bulked tanker milk (169 samples) tanker swabs and rinsing water samples were taken from time to time to test the efficacy of the tanker cleansing operations. Remedial action was taken where necessary.

PASTEURISED MILK

Raw milk is delivered to three pasteurising plants licenced to process milk and cream and various cultured milk products. Samples were obtained from each plant every week day and the following tests were carried out:—

	Pasteurised Milk	Cultured Milk Products etc.
Plate Count	1448	1413
Eijkmann Test	1448	1413
Presumptive Coliform Test	1448	1413
Phosphatase Test	1498	377

These tests included soft serve samples from some 200 retail outlets. Cultured milk products column includes ice cream, skim milk for school feeding schemes, flavoured skim milk, pasteurised cream, artificial cream, yogurt, cultured butter milk and soft cheese.

ANIMAL DISEASES

A survey is being carried out on the incidence of Brucellosis amongst dairy cattle in the Western Cape with an eventual aim of eradicating this disease. Further strides have also been taken in the state-controlled T.B. Eradication scheme. 87^{0}/o of producers have joined and it is envisaged that the remainder will do so in the near future.

Twelve final year Veterinary Science students gained public health experience with the Branch during the year.

VI-TESTS

234 tests were carried out during the course of the year.
All were negative.

B. MEAT CONTROL

The Municipal Abattoir, situated in Maitland, is a branch of the Town Clerk's Department. The Director and Assistant Director are veterinarians.

In addition to the above, three veterinary officers are employed to carry out meat inspection and other veterinary duties. Posts exist for thirty-four meat inspectors who are employed on meat inspection and other hygiene duties. A qualified microbiologist working in a well equipped laboratory is responsible for the checking of hygienic control of slaughter procedures and equipment as well as for diagnostic work.

The Abattoir was completed in 1966 at a cost of R3 000 000. It is a regional abattoir and provides meat for greater Cape Town and some of the adjoining towns of the Western Cape. Since completion, many structural and procedural improvements have been effected. During the period under review extensive changes were brought about at the pig abattoir and the mechanical beef slaughter line was completely overhauled.

At present the maximum daily throughput is 850 cattle, 150 calves, 5 000 sheep and goats and 600 pigs. In addition a few horses are killed. With the exception of pigs and horses all slaughter stock are killed and dressed on mechanical conveyor systems.

During 1976 the following animals were slaughtered: (figures in parenthesis are for 1975)

Cattle	177 050	(160 508)
Calves	16 840	(14 078)
Sheep and Goats	1 040 978	(1 053 939)
Pigs	117 612	(130 985)
Horses and Donkeys	897	(1 251)

The value of carcasses, excluding horses and donkeys, was R61 015 356 (70 308 845) for the year 1976. Carcasses with a potential market value of R217 630 were condemned for various disease conditions and rendered into by-products. In addition, meat valued at approximately R2 575 237 (R7 200 000) was brought into the Municipal area of Cape Town form other centres. This meat was reinspected by meat inspectors from the abattoir before sale to the public.

Hides and skins to the value of R4 673 029 (R2 194 074) were handled at the Abattoir and offal from slaughtered animals realised R2 845 935 (R3 083 381).

Condemned material and blood is rendered by the by-products plant into carcass meal, tallow and blood meal. During 1976 the sale of by-products realised R344 020 (R395 830). Table XI.VIII details diseases found upon slaughtering animals at the Abattoir in 1976.

A number of final year veterinary students from Onderstepoort saw practice at the abattoir during their vacation as part of their training in veterinary public health. Fourth year medical students as well as student health inspectors also received practical training in meat hygiene. Various scientific institutions in and around Cape Town were supplied with organ and other tissue material for research and teaching purposes.

I am indebted to the Branch Manager of the Livestock and Meat Industries Control Board for some of the information contained in this report.

BUTCHERS' DELIVERY VEHICLES

The continued enforcement of Regulation 1970 maintains the standard metal type of butchers vehicles in which all carcases are hung and are clear of the floor. During the year 217 meat delivery vehicles were licenced.

Meat inspection at a Supermarket

C. OTHER ASPECTS OF FOOD CONTROL

WHOLESALE MARKET

The Wholesale and Early Morning Market at Epping was designed specifically to meet the particular needs of Cape Town, the main hall is believed to be the biggest structure of its kind in Southern Africa. Ancillary buildings consisting of a three-platform railway terminal, administrative block, special auction block for graded and standardised products, loading platforms for 348 lorries, and minor facilities such as restuarant, rest rooms, etc. have also been built, and each one of these sections has been designed for extension when the need arises. A fulltime health inspector from the Health Department is responsible for the checking and control of all foodstuffs passing through this market.

The following foodstuffs were condemned as unfit for human consumption by the market health inspector during the year.

Fruit:–	Weight (Kg)	Vegetables:–	Weight (Kg)
Pome	17495	Bulbs	19377
Drupe	7223	Flowers	6612
Citrus	129557	Leaves and stems	140498
Vine	1759	Roots	15774
Miscellaneous	10739	Seed Fruits	296049
		Tubers	61495
		Other Foodstuffs	830

FOOD SAMPLING

In terms of section ten of the Foodstuffs, Cosmetics and Disinfectants Act, Act No 54 of 1972 the Cape Town City Council has been delegated with responsibility for sampling foodstuffs. The number of free examinations by the State Chemical Laboratory was fixed at 817 by the Secretary for Health on 1974–10–25. Sampling duties are undertaken by the five Divisional and eleven Senior Health Inspectors.

Table XI.IX details the samples taken during the year in terms of results and any action taken. Twenty nine ($3\,1/2\%$) of the samples analysed were adulterated and fines totalling R1 020 were imposed. While two out of four guava juice samples reflected the highest percentage of adulteration, many more samples of sausages and mince meat were taken, over 6% of which were adulterated.

CONDEMNATION OF FOODSTUFFS

Food which is unfit for human consumption is condemned in terms of regulations (R963 of 1966–06–24 as amended by R2 127 of 1974–11–22) made under the Public Health Act, Act No 36 of 1919. It is sometimes possible to use this food as poisoned rodent bait or in the by-products plant at the Abattoir.

The reasons for condemning food included simple spoilage of perishables, contamination by smoke and fumes, expiry of date stamped articles, contamination by dirt and exposure to contamination or spoilage by virtue of damage to containers (rusted, dented and blown tins), etc.

5. CONTROL OF TRADING

Reports on the suitability from a Public Health point of view of a wide range of commercial undertakings are submitted by the Medical Officer of Health before these are registered, licensed or issued with certificates.

Various Municipal By-Laws , Provincial Ordinances and Government Regulations govern these matters.

The various applications dealt with during 1976 are detailed in Table XI.XI; they totalled 5296 of which three were withdrawn and refusal recommended in twenty.

MUNICIPAL BY-LAWS

Annual licensing of traders purveying milk or packing milk in cartons, transporting milk by tanker, slaughtering poultry and contracting to do electrical wiring is required under these By-Laws. The Medical Officer of Health reports on these applications to the Amenities and Health Committee.

STABLE PREMISES

The Municipal By-Laws empower the Council to prohibit the use for the keeping of animals, of any stable, cowshed, pigstye, kraal, etc., which in its opinion is 'unfit', undesirable or objectionable by reason of its locality, construction or manner of use. The City Council may also restrict number or manner of use of those structures. The City Council may also restrict the number or kind of animal to be kept at any such premises.

10 cases of unsuitable and unauthorised structures which were being used to stable animals, were ordered to be demolished and the animals removed. In four cases the animals were removed and the structures demolished.

PROVINCIAL ORDINANCE OF 1953 (as amended by Ord 19 of 1972)

This Ordinance controls the Registration and Licensing of Businesses in respect of 54 scheduled undertakings. Reports on these applications are submitted to the Town Clerk by the Medical Officer of Health.

GOVERNMENT REGULATIONS

Mattress makers and upholsterers must register annually with the Council in terms of No. 1384 of 1938.

6. HOUSING

The greater part of the Cape Town municipality consists of houses built of masonry according to the standards of the time of their erection, served by the municipal water supply and water-borne sewerage, and with well-constructed streets. Most of the dwellings are separate houses built for one family each, detached, semi-detached or in terraces. Private enterprise is today making little or no provision for the housing of the lower income groups (owing to high building costs) and have concentrated on the erection of large blocks of flats. Such flat development is taking place all over the municipality, but far and away the most popular suburbs for such development are the Sea Point, Three Anchor Bay, Green Point and the Kenilworth areas. There is a decided danger in the overcrowding of any one area with large flat blocks owing to the danger of ultimate deterioration of both building and inmates and the possibility of slum conditions eventually developing.

If the houses were occupied in the manner originally intended, housing conditions would be mainly satisfactory. The chief factor responsible for slum conditions is the overcrowding caused by the fact that there are not enough houses for the population, itself the result of economic conditions. Houses suitable for one family and in many cases small even for one large family, are occupied by several families, sometimes to the extent of one family per room. The over-crowded families are naturally mostly from the poorest strata of society, usually (though not invariably) not White, and often of low social standard. The resulting squalor is increased by decay of the fabric of the houses which such occupation induces.

The same shortage of houses and economic stringency is largely responsible for the other side of the local problem, viz, the occupation of unauthorised and insanitary structures (pondoks, shacks) on the Cape Flats fringing Cape Town, often without made roads, water supply or sanitary services and sometimes subject to winter flooding. The Council has ample powers to prohibit such building and occupation, but has not found itself prepared to eject the occupants from the only shelter available to them. Indeed, an organised squatters camp at Vrygrond has been developed by the Council with roads, an orderly layout, refuse removal, water supply and pail closet sewage removals. Crime in such areas remains a problem but the most basic sheltering aspects of housing are present.

It is recommended that urgent priority be given to site and service schemes, despite the argument that organised shanty towns become permanent shanty towns. This need not be so as has been previously stressed in this Report page 75 . It is intolerable that human beings should be expected to live without shelter in the precincts of what is ostensibly an advanced and civilised City.

There remains also the lowest sub-economic group of the population who are a social welfare problem and cannot be provided for through minicipal housing.

These housing conditions are of long standing, and have been the subject of repeated consideration by the Council, its committees and officers.

The Council is erecting houses departmentally as well as by contract. The building units function with artisans recruited from the building industry and working under conditions of service applicable to that industry. Coloured housing is based on standard plans evolved by the National Housing Commission.

With the enforcement of the Group Areas Act and the displacement of racial groups from one area to another even more housing for the Coloured Community must be constructed each year. It is difficult to formulate any figure but it is estimated that at least 20 000 units must be erected so as to make any impression on the present overcrowding that exists.

In the preparation of the Manenberg scheme (an extension of Heideveld), the Council was originally faced with a demand for a 100 per cent allocation of the houses for State population regrouping purposes. To minimise urban sprawl, it had been anticipated that high density flat construction would be utilised in areas such as 'District Six', but the Council has had to abandon that scheme and is now faced with the problem of providing such accommodation elsewhere in the City.

Cape Town's topography has been the reason for siting the major municipal housing scheme around Athlone, about 13 km from the City centre.

The dwellings completed by the City Council in the year under review are detailed in Table XI.XII.

After taking into account conversion, sale or demolition of dwellings the 830 dwellings completed in 1976 bring the total of dwellings completed and under the control of the Housing Branch within the Cape Town Municipal area (excluding the Bantu Affairs Administration Board Areas, dwellings used to accomodate caretakers or to house clinics etc.) to 39 953 (1 455 White and 38 498 Coloured). Four blocks of single quarters for 816 Black men were erected at Guguletu.

The Director of Housing has furnished the information (see Table XI.XII) that during 1976 three economic dwellings were built in Albowville (White), 234 were built for Coloured occupation and five dwellings were restored in the Malay Quarter.

No White home-ownership houses were built but 588 such dwellings for Coloureds were completed at Mitchells Plain in 1976 ($12^1/2^0/o$ of these houses were allocated to the Department of Community Development for resettlement of displaced families under the Group Areas Act).

The application list for Council housing increased by 2380 to 19609 Coloured families but White applications decreased by 35 to 537. Approximately $20^0/o$ of Coloured and $57^0/o$ of White applicants qualify for economic housing.

A total of 1 157 families from the waiting list were housed during the year – 194 in new dwellings and 963 in vacancies. In addition to this 35 families were resettled by the Department of Community Development. Of existing occupants, 313 families were transferred to new dwellings and 929 to vancancies.

THE HOUSING ACT (Act No 4 of 1966).

Before the demolition, or conversion to uses other than residential, of residential accommodation, permission must be obtained from either the Department of Community Development (in the case of "dwellings", which have not more than five living rooms) or the local authority (in the case of other premises).

The Cape Town City Council has delegated its powers under the Act to the Medical Officer of Health who submits recommendations to the Department of Community Development in respect of dwellings and who grants or refuses permission in the case of larger premises.

Dwellings are covered by S.85 (1) of the Act and recommendations concerning 124 such applications were submitted to the Department of Community Development in 1976 (see Table XI:XIII).

Other premises (with more than five living rooms) are covered by S.85 (4) of the Act and 13 such applications were granted in 1976 (see Table XI.XIII).

THE SLUMS ACT (Act No. 53 of 1934)

An application to have a property comprising 7 brick-built dwellings and 32 unauthorised wood and iron shacks declared a slum was made during 1976 and has not reached finality.

In respect of four other properties the court, acting in terms of S.15 (2) of the Act, rescinded the slum declaration as the buildings had been demolished and the site cleared.

7. SEWERAGE

With the exception of outlying sparsely developed areas the greater part of the Municipality is provided with water-borne sewerage facilities.

The principal sewage treatment plant is located at Athlone with a dry weather flow of 100 megalitres per day. The Athlone plant is now completely surrounded by residential areas and is only 8 kilometres from the centre of the City.

Approximately 23 megalitres of sewage from the Wynberg-Clovelly area plus approximately 14 megalitres of sewage from Guguletu, Nyanga and the developing areas of the Cape Flats, as well as 12 megalitres from Epping II are treated in re-circulated photosynthetic ponds at the Strandfontein Road Cape Flats Sewage Treatment Works.

The Council in terms of an agreement with the Cape Divisional Council, accepts and treats sewage from Goodwood, Parow and the Divisional Council Local Area of Epping Garden Village. Similarly the Council accepts and treats sewage from Pinelands and from such portions of the Divisional Council Local Area of Grassy Park as are presently sewered; sewage from part of the Constantia Local Area is now being accepted into the Council system.

The Council has negotiated an agreement with Milnerton to discharge sewage northwards to link up with their sewage treatment works.

With the commissioning in November 1974 of the Sanddrift East Pumping Station the sewage from this Estate is now passed to the Montague Gardens interceptor and then direct to the Milnerton Sewage Treatment Works.

Council on 1973–07–31 adopted a policy of separation of industrial from domestic effluents so far as practicable to supplement and assist future efforts in the reclamation and re-use of sewage effluent; it has authorised the expenditure of R21 000 000 for a new treatment plant at the Cape Flats and improvements and additions to the Athlone Treatment Works, with an ultimate capacity of 180 megalitres per day.

Consultants have been appointed to do work in connection with the above and a new by-pass line to relieve some of the load to Athlone has been constructed.

The area from Woodstock to Bakoven is sewered and the sewage discharged to sea in two outfalls (Green Point and Camps Bay) after maceration; chlorination is used, in addition, at Camps Bay. A contract has been awarded and work is nearly completed on the new submarine outfall sewer at Camps Bay.

In order to be ready for sewage treatment from the Mitchell's Plain Housing Development, contracts for the design and construction of the first stage (capacity 6,2 megalitres per day) of the Sewage Works have been let and work is to proceed early in 1975. The ultimate capacity will be 50 megalitres per day.

PAIL CLOSETS

Regular removals of night soil were effected from all premises requiring such service in unsewered areas. Pail contents are disposed of by discharging into the sewage system through the intake at Muizenberg 267156 pail clearances were affected. Similarly 17637 removals were made from O'Brien dry earth closets in the municipal and certain abutting areas.

PUBLIC SANITARY CONVENIENCES

This Department has under its control 53 public sanitary conveniences (chalets) sited at convenient points throughout the municipal area, and which are staffed by 145 permanent attendants.

8. SURFACE SANITATION

A. REFUSE REMOVAL

DOMESTIC REFUSE REMOVALS

The removal of domestic refuse is carried out by the Cleansing Branch of the City Engineer's Department as follows:—

Every Week-day:

Cape Town Central Business district:—

Hotels, Restaurants, Boarding Houses and certain flats and business premises in congested areas.

Three Times Weekly:

Camps Bay, Sea Point, Green Point, Oranjezicht, Tamboerskloof, Woodstock, Salt River, Observatory, Brooklyn, Maitland, Kensington and Bishopscourt.

Twice Weekly:

Mowbray, Rosebank, Rondebosch, Upper Newlands, Upper Claremont, Lower Claremont, Lower Newlands, Kenilworth, Wynberg, Plumstead, Retreat, Lakeside, Bergvliet, Athlone, Lansdowne, Bonteheuwel, Manenberg, Hanover Park, Parkwood Estate, Sanddrift and Thornton.

Sundays:

On Sundays a special payments removal is effected at Hotels, Restaurants and Boarding Houses.

DISPOSAL OF REFUSE

All refuse, both trades and household, was disposed of at the Council's tip at Guguletu until this was closed during 1976. Strict control of the tip by the adoption of sanitary control methods is adhered to. The disposal sites now in use are situated at Strandfontein and Vissershoek.

During the year the quantity of refuse removed was 1325700 cubic metres, compacted to 662 850 cubic metres.

As the available areas for controlled tipping of refuse are steadily diminishing or suitable areas so far away that transport costs become prohibitive, the City Council decided to investigate the pulverisation of refuse prior to disposal as landfill or for the manufacture of compost after maturation.

Investigations have been concluded and contracts awarded for the erection of a Pulverising Plant on a site adjoining the Athlone Power Station. Work on the project is scheduled to commence in January 1977.

Camps Bay sewerage outfall under construction

B. STORMWATER DRAINAGE

A great part of the Municipality, being built on the slopes at the foot of the mountain, is well sited for drainage but in parts of the Cape Flats natural drainage scarcely exists and in the wet season the groundwater level over a considerable area rises to or very near the surface.

The City is mostly sewered on the separate system, the stormwater being conducted by separate channels to the nearest outfall namely the sea, or into the Liesbeeck and Black Rivers, which drain the southern suburbs north of Kenilworth and flow into Table Bay as the Salt River. South of Kenilworth the streams run south and discharge into a series of vleis or lakes and thence to the sea at False Bay. The Mouille Point sewerage outfall is overloaded because it takes stormwater as well.

It is the policy of the City Council to concrete-line the banks and inverts of natural watercourses in its area where required by hydraulic or planning considerations. The Vygekraal River upstream of Vanguard Drive has been widened and deepened and the lining of this section of the river has been taken as far as Sherwood Park on the boundary of the Municipal Area. The Council is currently participating in the Canalisation of the Elsieskraal River at Thornton and the widening of the Blomvlei Canal in Athlone.

C. PEST CONTROL

PLANS

Prevention of rodent problems begins with a well-designed building and plans are therefore scrutinised by two pest control officers seconded to the Building Survey Branch of the City Engineers Department, who scrutinized 4 293 plans and minor works permits during 1976 compared with 3 636 in the previous year. These officers also scrutinise other health aspects of plans such as floor space, room volume, ventilation etc.

PEST CONTROL OFFICERS

The two pest control officers primarily responsible for the rodent, mosquito and cockroach control measures in the city are assisted by 26 rodent operatives, whose duties involve routine blockbaiting with Warfarin and its derivatives for rodent control. In the year under review, 12 600 kg. of bait were laid. The rodent control work conducted during 1976 is detailed in Table XI.XIV.

The rapid building expansion that has and is taking place on what used to be wide open spaces is rapidly reducing the Gerbille population and anti-gerbille work is carried out only when and where necessary.

MOSQUITOES

The pest control officers also specialise in anti-mosquito work. They investigate local prevalence of mosquitoes discovered through complaints or systematic inspection. They also institute permanent anti-mosquito measures in the Black River, extending from the Bokmakierie Township to the Royal Observatory, as well as giving attention to seasonal collections of standing water and other known mosquito breeding foci within the municipal area. Two of the operators under their control devote the whole of their time to oil-spraying of waters where mosquitoes are likely to breed, including oil treatment of standing water at the sewage disposal works, Athlone.

COCKROACHES

In addition to dealing with anti-rodent work and mosquito control, an increasingly important section of environmental sanitation has been the control of cockroaches in food establishments and foul and storm-water sewers.

These tasks are shared by the district health inspectors and the pest control officers. Where infestation is traced to the municipal sewers control measures are carried out by the City Engineer's Roads and Drainage staff.

Complaints of cockroach infestation are investigated jointly by the City Engineer's Department and this Department and appropriate action taken according to the locality of any infestation discovered.

HYDROGEN CYANIDE FUMIGATION

Under the Hydrogen Cyanide Fumigation Regulations (Government Notice Nos. 804 of 1943–04–30; and 605 of 1945–04–13), no person may undertake the fumigation of any 'building or premises' with hydrogen cyanide unless he has obtained a certificate of competence from the State Health Service or a "First Schedule" local authority. Certificates granted by local authorities are subject to confirmation and counter-signature by the Secretary for Health. A certificate may not be issued unless the candidate worked for 12 months as a fumigator prior to 1943–04–30, or has worked for six months under a certified fumigator.

In August, 1943, the Medical Officer of Health, Cape Town, was requested and authorised by the Secretary for Health to undertake the examination and certification (subject to the prescribed confirmation), of candidates from areas outside Cape Town not under 'First Schedule' authorities.

No certificates were issued during 1976.

Table I.I *SUMMARY OF VITAL STATISTICS : 1976*

Area :– 29970,2893 Hectares

	WHITE		COLOURED		ASIANS		BLACKS		ALL RACES	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Total population	253570		477470		11050		100530		842620	
Notified Live Births	3186	12,6	12076	25,6	264	23,9	4115	40,9	19641	23,3
Registered Deaths	2219	8,75	3231	6,77	50	4,52	1247	12,40	6747	8,01
Natural Increase	967	3,8	8845	18,5	214	19,4	2868	28,5	12894	15,3
Infant Mortality (Death under one year)	33	10,4	381	31,6	1	3,8	325	79,0	740	37,7
Maternal mortality			5	0,41			4	0,95	9	0,45

Table I.II

INCOME AND EXPENDITURE, CITY HEALTH DEPARTMENT : 1975 – 1976

	1975 ACTUAL	1976 ACTUAL	1976 ESTIMATE
EXPENDITURE			
Salaries, Wages and Allowances	R3 364 842	R3 634 442	R3 673 710
General Expenses	R1 408 941	R1 409 576	R1 810 950
Repairs and Maintenance	R 123 063	R 127 284	R 167 940
Interest and Redemption	R 97 151	R 108 129	R 116 245
TOTAL EXPENTITURE	R4 993 997	R5 279 431	R5 768 845
INCOME			
Refund and Subsidies from State and Provincial Authorities	R2 689 391	R2 758 711	R3 326 165
Fees and Sundry Income	R 210 063	R 185 430	R 196 275
Contribution from Rates	R2 094 543	R2 335 290	R2 246 405
TOTAL INCOME	R4 993 997	R5 279 431	R5 768 845

Table I.II

Table II.I *METEOROLOGICAL DATA 1967 TO 1976 : D F MALAN AIRPORT WEATHER OFFICE*

	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Total rainfall	485,6 mm	604,7 mm	428,7 mm	555,6 mm	361,5 mm	424,1 mm	321,0 mm	682,6 mm	558,4 mm	565,4 mm
No. of rainy days	124	134	105	132	56	125	95	96	117	130
Ave. Max. Temp.	21,7	29,7	31,0	28,0	27,0	22,5	23,1	22,2	21,1	21,4
Maximum Tep.	35,0	37,3	40,7	36,2	38,3	39,9	35,5	37,4	38,1	35,2
Ave. Min. Temp.	10,9	4,1	5,3	5,1	7,2	11,6	11,7	11,6	11,9	12,0
Minimum Temp.	0,4	0,2	0,8	1,0	0,0	0,7	0,3	0,9	0,5	0,2

Table II.I

Table III.I *ESTIMATED POPULATION OF THE CITY OF CAPE TOWN BY RACE 1957 TO 1976*

	WHITE	COLOURED	ASIATIC	BLACK	TOTAL
1957	191380	222550	7070	63000	484000
1958	192150	228300	7120	64000	491570
1959	192930	234720	7170	64500	499320
1960	193710	266020	7210	64790	531730
1961	195650	275040	7380	66390	544460
1962	197910	285280	7570	68030	558790
1963	200210	295890	7780	73480	577360
1964	202530	306910	7980	73540	590960
1965	204880	318330	8200	78600	610010
1966	207250	330180	8420	88930	634780
1967	209650	342470	8640	90000	650760
1968	212080	355210	8870	80840	657000
1969	214540	368430	9110	84460	676540
1970	217030	382150	9350	85700	694230
1971	235550	397500	9660	93050	735760
1972	239050	412340	9920	91150	752460
1973	242600	427740	10190	90250	770780
1974	246200	443710	10470	95000	795380
1975	249860	460280	10760	97730	818630
1976	253570	477470	11050	100530	842620

Table III.II

ESTIMATED POPULATION, BIRTH RATES, DEATH RATES, NATURAL INCREASE RATES AND INFANT MORTALITY RATES : 1951 TO 1976

PERIODS	Estimated Populations			Birth rates			Death rates corrected for outward transfers			Natural increase rates			Infant mortality rates		
	White	Coloured Asiatic Blacks	Total	White	Coloured Asiatic Blacks	Total	White	Coloured Asiatic Blacks	Total	White	Coloured Asiatic Blacks	Total	White	Coloured Asiatic Blacks	Total
YEAR															
1950—1951	186790	255510	442300	18,02	41,40	30,16	9,55	14,97	12,00	8,47	26,43	18,56	23,91	104,20	84,07
1951—1952	187540	261280	448820	18,27	40,94	31,26	9,88	14,99	12,82	8,39	25,95	18,43	28,78	106,26	87,26
1952—1953	188300	267220	455520	18,37	39,42	30,62	9,33	13,12	11,54	9,04	25,30	19,08	21,29	101,35	81,32
1953—1954	189070	273310	462380	18,23	37,86	29,86	9,03	12,25	11,09	8,86	25,61	18,77	30,43	100,55	83,71
1954—1955	189830	279580	469410	17,62	36,95	29,26	9,15	11,52	10,60	8,47	25,43	18,66	21,45	100,80	82,52
1956	190600	286010	476610	18,6	34,3	28,3	9,0	10,3	10,2	8,6	23,9	18,0	24,5	103,0	83,4
1957	191380	292620	484000	18,4	36,5	29,8	10,0	10,6	10,4	8,5	25,9	19,4	23,5	95,5	79,3
1958	192150	299420	491570	18,8	34,4	28,7	9,7	9,9	9,8	9,2	24,4	18,8	23,1	97,6	80,2
1959	192930	306390	499320	19,2	34,3	28,9	10,0	8,6	9,1	9,2	25,7	19,8	17,5	80,2	65,5
1960	193710	338020	531730	18,4	38,3	31,1	10,9	10,5	10,7	7,3	24,7	18,7	25	81	69
1961	195650	348810	544460	18,9	36,4	30,1	10,2	9,5	9,8	8,7	26,8	20,3	20	76	64
1962	197910	360880	558790	18,9	35,2	29,4	10,4	8,7	9,3	8,5	26,5	20,1	22	70	59
1963	200210	377150	577360	18,1	36,2	29,9	10,1	10,3	10,2	7,9	25,9	19,6	23	86	73
1964	202530	388430	590960	18,3	37,3	30,8	10,6	10,3	10,4	7,7	27,0	20,4	19	78	66
1965	204880	405130	610010	16,8	38,4	31,2	10,2	10,6	10,5	6,6	27,8	20,7	19	78	68
1966	207250	427530	634780	18,0	35,1	29,5	10,5	9,8	10,0	7,5	25,4	19,5	17	78	66
1967	209650	441110	650760	18,0	31,6	27,2	10,0	9,9	10,0	8,0	21,7	17,3	15	79	66
1968	212080	444920	657000	18,1	38,4	31,8	10,2	9,3	9,6	7,9	29,1	22,2	15	58	50
1969	214540	462000	676540	18,4	37,4	31,4	10,3	9,3	9,7	8,1	28,0	21,7	18	58	51
1970	217030	477200	694230	19,2	35,2	30,2	10,6	9,6	9,9	8,6	25,6	20,3	16	59	50
1971	235550	500210	735760	18,3	35,5	30,0	9,0	7,8	8,2	9,2	27,6	21,7	13	46	39
1972	239050	513410	752460	17,1	35,1	29,4	9,0	7,4	7,9	8,1	27,7	21,5	13	38	34
1973	242600	528180	770780	15,6	34,6	28,6	9,4	8,3	8,6	6,2	26,3	20,0	13	46	40
1974	246200	549180	795380	14,6	32,8	27,2	9,1	8,0	8,3	5,5	24,8	18,9	12	46	40
1975	249860	568770	818630	13,2	29,2	24,3	8,4	7,2	7,6	4,7	22,0	16,7	12	38	34
1976	253570	589050	842620	12,6	27,9	23,3	8,8	7,7	8,0	3,8	20,2	15,3	10	43	38

City extended in 1971 by incorporation of districts of Thornton, Bergvliet, Meadowridge, Ottery (part) and Kirstenhof.

The population and rates for the years 1961 onward have been corrected according to the final figures of the 1970 census. Birth rates based on notification from 1968.

Table III.III POPULATION BY RACE AND SEX : 1975 TO 1976

RACE	1975			1976		
	MALES	FEMALES	PERSONS	MALES	FEMALES	PERSONS
WHITE	118900	130960	249860	120700	132870	253570
COLOURED	216360	243920	460280	224410	253060	477470
ASIATIC	5590	5170	10760	5750	5300	11050
BLACKS CITY	9477	3521	12998	9279	4260	13539
BLACKS LANGA	26023	4326	30349	27399	4359	31758
BLACKS GUGULETU	28150	26233	54383	28672	26561	55233
BLACKS TOTAL	63650	34080	97730	65350	35180	100530
TOTAL	404500	414130	818630	416210	426410	842620

Table III.IV

AGE-RACE POPULATION DISTRIBUTION OF WHITE AND COLOURED RESIDENTS OF PROPOSED CAPE TOWN HEALTH DISTRICTS (1970 CENSUS DATA).

RACE	N1	N2	N3	N4	N5	N6	N7	E1	E2	E3	E4	E5	E6	E7	E8	S1	S2	S3	S4	S5	S6	S7	TOTAL	%	01 ECONOMIC REGION % *
WHITES																									
65 +	129	3342	5809	2031	1380											3672		116		571	5008		22013	9,97	8,7
60—64	96	1802	2938	1053	695											1900		78		398	2520		11480	5,2	4,9
55—59	109	1838	2785	1132	1036											2248		68		528	2639		12383	5,61	4,8
50—54	118	1673	2431	1106	1085											2494		97		556	2478		12038	5,45	5
45—49	124	1812	2376	1081	1220											2892		104		726	2671		13006	5,89	5,9
40—44	143	1764	2097	1044	1278											2882		97		784	2440		12529	5,67	5,7
35—39	140	1786	1973	1036	1337											2980		82		811	2353		12498	5,66	5,8
30—34	123	2172	2214	1048	1384											3345		102		885	2499		13772	6,24	6,6
25—29	143	3291	3228	1354	1583											3806		96		923	3393		17817	8,07	8,1
20—24	188	3856	3404	1983	1971											4293		111		958	5159		21923	9,93	9,2
15—19	176	2556	2240	1756	1827											3890		157		1156	4650		18408	8,34	8,7
10—14	209	2135	1898	1535	2023											4418		165		1443	3795		17621	7,98	9
5— 9	220	1963	1844	1583	1979											4735		129		1464	3269		17186	7,78	9,1
0— 4	226	2273	2182	1772	2091											4826		129		1450	3217		18166	8,23	8,6
																							220840	100,02	100,1
COLOURED																									
65 +	1453	346	66	614	190		989	1728	438		430	590	629	211		1080	816	115	285	755	123		10762	2,84	2,7
60—64	910	251	72	412	158		630	1194	312		275	410	357	129		696	492	72	167	490	105		7075	1,86	2,1
55—59	1097	322	128	461	163		788	1493	431		361	533	502	158		902	707	104	198	650	136		9080	2,39	2,1
50—54	1187	386	154	486	218		912	1689	492		440	682	601	162		985	886	158	239	685	192		10564	2,78	2,6
45—49	1371	469	253	587	265		1250	2039	675		608	937	1019	294		1145	1290	172	323	821	235		13721	3,61	3,5
40—44	1699	616	328	735	271		1665	2250	983		862	1402	1491	445		1351	1680	262	444	1028	304		17715	4,67	4,8
35—39	2011	637	386	915	319		1947	2470	1476		1121	2477	2160	651		1638	2144	344	682	1242	415		22721	5,99	6
30—34	2288	805	529	1013	383		1855	2500	1951		1204	2883	2202	704		1892	2059	337	841	1396	483		25048	6,6	6,5
25—29	2770	1025	666	1125	487		2120	3395	2237		1190	2675	1418	492		2223	1842	427	945	1608	622		27354	7,21	7
20—24	3443	1485	1015	1324	762		3168	5419	2085		1493	2490	2001	586		2570	2675	579	1031	2138	662		34919	9,2	9,3
15—19	3875	1343	514	1305	763		4048	6237	2313		1597	3292	3394	906		2780	4106	652	1119	2093	491		40574	10,69	11,4
10—14	4111	1104	109	1428	610		4727	6284	3163		1885	4441	5393	1664		2891	5493	847	1552	2188	201		47324	12,47	13
5— 9	4777	1092	120	1563	688		4883	6212	4661		2250	6664	6539	2137		3229	5910	1049	1995	2529	191		55401	14,6	14,9
0— 4	5198	1217	253	1762	810		4996	6845	5588		2293	6631	4869	1716		3536	5232	1277	2332	2830	369		57315	15,1	14,1
																							379575	100,01	100

* from Figure 3.2.

Table III.V NOTIFIED LIVE BIRTHS AND BIRTH RATES BY RACE AND SEX OF INFANT : 1975 TO 1976

RACE	MALES		FEMALES		TOTAL		BIRTH RATE	
	1975	1976	1975	1976	1975	1976	1975	1976
White	1 657	1 589	1 631	1 597	3 288	3 186	13,2	12,6
Coloured	6 369	6 121	5 971	5 955	12 340	12 076	26,8	25,3
Asiatic	116	146	124	118	240	264	22,3	23,9
Blacks	2 007	2 067	2 024	2 048	4 031	4 115	41,2	40,9
TOTAL	10 149	9 923	9 750	9 718	19 899	19 641	24,3	23,3

Table III.VI NOTIFIED BIRTHS AND BIRTH RATES BY RACE : 1972 TO 1976

RACE	1972		1973		1974		1975		1976	
	LIVE BIRTHS	BIRTH RATE	LIVE BIRTHS	BIRTH RATE	LIVE BIRTHS	BIRTH RATE	LIVE BIRTHS	BIRTH RATE	LIVE BIRTHS	BIRTH RATE
White	4 092	17,1	3 780	15,6	3 593	14,6	3 288	13,2	3 186	12,6
Coloured	14 156	34,3	14 080	32,9	13 530	30,5	12 340	26,8	12 076	25,3
Asiatic	182	18,3	250	24,5	241	23,0	240	22,3	264	23,9
Blacks	3 682	40,4	3 931	43,6	4 250	44,7	4 031	41,2	4 115	40,9
TOTAL	22 112	29,4	22 041	28,6	21 614	27,2	19 899	24,3	19 641	23,3

Table III.VII *NOTIFIED STILL BIRTHS AND STILL BIRTH RATES BY RACE : 1975 TO 1976*

RACE	NOTIFICATIONS			
	NUMBER		STILL BIRTH RATE	
	1975	1976	1975	1976
WHITE	22	26	6,6	8,1
COLOURED	195	203	15,6	16,5
ASIATIC	3	2	12,3	7,5
BLACKS	97	91	23,5	21,6
TOTAL	317	322	15,7	16,1

Table III.VIII *NOTIFIED TWIN BIRTHS CLASSIFIED ACCORDING TO RACE AND AS TO WHETHER OF THE SAME OR MIXED SEXES : 1976*

		CHILDREN		
RACE	NO. OF PAIRS	BOTH MALES	BOTH FEMALES	MIXED
WHITE	36	10	14	12
COLOURED, ASIATIC AND BLACKS	185	61	59	65
TOTAL	221	71	73	77

Table III.IX *NOTIFIED LIVE AND STILL BIRTHS IN INSTITUTIONS (WHETHER OCCURRING IN OR OUT OF THE MUNICIPAL AREA) TO CAPE TOWN MUNICIPAL RESIDENTS : 1975 TO 1976*

	NOTIFICATIONS			
	NUMBER		PERCENTAGE OF TOTAL MATERNITIES	
	1975	1976	1975	1976
WHITE	3 245	3 169	98	99
COLOURED	8 554	8 936	69	73
ASIATIC	179	220	74	83
BLACKS	3 066	3 124	76	74
TOTAL	15 044	15 449	75	77

Table III.X *NOTIFIED LIVE AND STILL BIRTHS (WHETHER TO RESIDENTS OR NON-RESIDENTS) BY PLACE OF OCCURRENCE AND ATTENDANT, OCCURRING WITHIN THE MUNICIPAL AREA OF CAPE TOWN : 1976*

ATTENDED	BIRTHS	PERCENTAGE
(a) In private houses:		
By private doctors	1	0,0
By private midwives		
Certificated	2 970	12,4
Uncertificated		
By institutional midwives or student midwives	1 598	6,7
No doctor or midwife		
	4 569	19,1
(b) In institutions:		
Public institutions	17 856	74,8
Private Nursing homes	1 436	6,0
	19 292	80,9

3 918 of these births were to non-residents of Cape Town.

Table III.XI *ILLEGITIMATE LIVE BIRTHS NOTIFIED BY RACE : 1975 TO 1976*

RACE	NOTIFICATIONS			
	NUMBER		PERCENTAGE OF TOTAL LIVE BIRTHS	
	1975	1976	1975	1976
WHITE	316	333	9,6	10,5
COLOURED	4 689	4 773	38,0	39,5
ASIATIC	10	8	4,2	3,0
BLACKS	2 312	2 394	57,4	58,2
TOTAL	7 327	7 508	36,8	38,2

Table III.XII *NOTIFIED BIRTHS TO TEENAGE MOTHERS BY RACE, LEGITIMACY AND AGE OF THE MOTHER 1976*

AGE OF MOTHER

	13 years		14 years		15 years		16 years		17 years		18 years		19 years		Total	
RACE	LEG	Illeg	LEG	Illeg	LEG	Illeg	LEG	Illeg	LEG	Illeg	LEG	Illeg	LEG	Illeg	LEG	Illeg
White				1	2	11	19	23	41	38	83	48	95	37	240	158
Coloured		1		16	7	72	23	177	93	368	205	562	282	559	610	1 755
Asiatic									2	2	2		8		12	2
Blacks		3		7	9	31	8	93	10	112	41	162	44	199	103	607
TOTAL		4		24		114	50	293	146	520	331	772	429	795	965	2 522

LEG: Legitimate
Illeg: Illegitimate

Table III.XIII *ILLEGITIMATE BIRTHS AS A PERCENTAGE OF TOTAL BIRTHS : 1951 TO 1976*

PERIODS	ILLEGITIMATE BIRTHS PERCENTAGE OF TOTAL BIRTHS		
	WHITE	COLOURED, ASIATIC AND BLACKS	TOTAL
YEAR			
1950—1951	2,96	24,08	19,42
1951—1952	3,11	25,40	19,86
1952—1953	3,38	24,58	19,26
1953—1954	3,59	24,55	19,30
1954—1955	2,65	23,66	18,59
1956	3,0	24,2	18,9
1957	3,6	24,7	19,8
1958	4,0	23,7	19,0
1959	4,1	23,8	19,2
1960	4,0	23,2	19,0
1961	3,8	23,3	19,0
1962	3,9	23,4	19,0
1963	4,7	24,2	20,1
1964	4,8	25,4	21,2
1965	4,6	27,0	22,9
1966	5,9	28,1	23,7
1967	8,3	29,9	25,3
1968	9,4	27,5	24,1
1969	7,8	28,6	24,7
1970	8,0	31,2	26,6
1971	7,5	33,4	28,3
1972	9,2	37,3	32,1
1973	10,1	39,1	34,2
1974	9,8	40,4	35,3
1975	9,6	42,2	36,8
1976	10,5	43,6	38,2

Table III.XIV — *NOTIFIED LIVE AND STILL BIRTHS BY RACE, LEGITIMACY, OCCURRENCE IN INSTITUTIONS AND MUNICIPAL WARD OF RESIDENCE : 1976*

WARDS	WHITE							COLOUREDS, ASIATICS AND BLACKS							TOTALS			STILL-BIRTHS				Total still births	Percentage of total births, including still-births, occurring in institutions	
	Legitimate		Illegitimate		Total			Legitimate		Illegitimate		Total						White		Coloureds Asiatics and Blacks				
	Males	Females	Males	Females	Males	Females	Total	Males	Females	Males	Females	Males	Females	Total	White	Coloureds Asiatics and Blacks	Total	Legitimate	Illegitimate	Legitimate	Illegitimate		White	Coloureds Asiatics and Blacks
1.	38	55	3	—	41	55	96	6	7	16	13	22	20	42	96	42	138	—	—	—	1	1	100	98
2.	43	42	1	2	44	44	88	3	6	25	15	28	21	49	88	49	137	—	—	—	—	—	99	98
3.	87	74	6	4	93	78	171	5	7	19	16	24	23	47	171	47	218	1	2	—	4	7	98	100
4.	52	45	3	6	55	51	106	76	63	29	29	105	92	197	106	197	303	—	—	2	3	5	98	94
5.	112	98	18	8	130	106	236	18	12	22	24	40	36	76	236	76	312	1	—	1	3	5	99	96
6.	4	9	1	3	5	12	17	47	43	38	34	85	77	162	17	162	179	—	—	1	—	1	100	96
7.	1	—	4	1	5	1	6	3	3	2	1	5	4	9	6	9	15	—	—	—	—	—	83	100
8.	59	66	17	8	76	74	150	318	285	172	150	490	435	925	150	925	1075	—	1	8	4	13	85	94
9.	158	161	16	12	174	173	347	355	340	213	234	568	574	1142	347	1142	1489	5	—	8	12	25	98	91
10.	75	77	10	10	85	87	172	9	1	4	4	13	5	18	172	18	190	3	—	—	4	7	98	86
11.	92	98	3	2	95	100	195	—	2	6	7	6	9	15	195	15	210	1	—	—	1	2	99	87
12.	50	50	1	1	51	51	102	6	4	1	4	7	8	15	102	15	117	3	—	—	—	3	99	87
13.	89	91	11	8	100	99	199	3054	2938	2349	2363	5403	5301	10704	199	10704	10903	2	—	99	102	203	99	72
14.	133	150	57	60	190	210	400	19	29	17	19	36	48	84	400	84	484	1	—	—	1	2	99	74
15.	151	131	14	18	165	149	314	117	100	37	33	154	133	287	314	287	601	2	—	—	—	2	99	82
16.	195	220	7	6	202	226	428	171	147	120	114	291	261	552	428	552	980	2	—	5	7	14	99	61
17.	73	74	5	7	78	81	159	530	556	527	517	1057	1073	2130	159	2130	2289	1	1	11	19	32	100	63
Not allocated (unascertained addresses)											1		1	1		1	1							
TOTAL	1412	1441	177	156	1589	1597	3186	4737	4543	3597	3578	8334	8121	16455	3186	16455	19641	22	4	135	161	322	99	73
Births in Cape Town which did not belong thereto	776	721	16	31	792	752	1544	692	683	455	457	1147	1140	2287	1544	2287	3831	7	—	34	26	67	100	98
* Langa								255	245	440	442	695	687	1382		1382	1382			8	19	27		96
* Guguletu								562	579	690	678	1252	1257	2509		2509	2509			24	31	55		62

* Included in Main Table

Table III.XV *UNCORRECTED AND CORRECTED DEATHS AND CORRECTED CRUDE DEATH RATES BY RACE AND SEX : 1975 TO 1976*

RACE	UNCORRECTED						CORRECTED											
	DEATHS						DEATHS						RATE					
	1975			1976			1975			1976			1975			1976		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
WHITE	1418	1198	2616	1462	1287	2749	1118	991	2109	1163	1056	2219	9,4	7,6	8,44	9,6	7,9	8,75
COLOURED	2064	1644	3708	2261	1742	4003	1620	1307	2927	1791	1440	3231	7,5	5,4	6,36	8,0	5,7	6,77
ASIATIC	43	10	53	31	22	53	31	9	40	28	22	50	5,5	1,7	3,72	4,9	4,2	4,52
BLACKS	882	435	1317	958	536	1494	751	365	1116	805	442	1247	11,8	10,7	11,42	12,3	12,6	12,40
TOTAL	4407	3287	7694	4712	3587	8299	3520	2672	6192	3787	2960	6747	8,7	6,5	7,56	9,1	6,9	8,01

Table III.XVI *CORRECTED DEATHS AND DEATH RATES BY RACE : 1972 TO 1976*

(**N.B.** 1972 figures are estimates for reasons detailed in the annual report for that year).

RACE	1972		1973		1974		1975		1976	
	DEATHS	DEATH RATE	DEATHS	DEATH RATE	DEATHS	DEATH RATE	DEATHS	DEATH RATE	DEATHS	DEATH RATE
WHITE	1 253 (2 148)	8,99	2 281	9,40	2 227	9,05	2 109	8,44	2 219	8,75
COLOURED	1 772 (3 038)	7,37	3 256	7,61	3 263	7,35	2 927	6,36	3 231	6,77
ASIATIC	34 (58)	5,85	55	5,40	39	3,72	40	3,72	50	4,52
BLACKS	414 (710)	7,79	1 052	11,66	1 079	11,36	1 116	11,42	1 247	12,40
ALL RACES	3 473 (5 954)	7,91	6 644	8,62	6 608	8,31	6 192	7,56	6 747	8,01

Table III.XVII

CORRECTED DEATHS BY AGE AND SEX FOR DEFINED GROUPS OF CAUSES : 1976

CAUSE OF DEATH	RACE	AGE GROUP																								TOTALS			Bantu Townships included in main table				Non Resident cases excluded from main table	
		< 1 year		1 year		2 to 4		Total under 5		5 to 9		10 to 14		15 to 24		25 to 34		35 to 44		45 to 54		55 to 64		65 to 74		75 to 84		85 and upwards					Langa		Guguletu			
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Persons	M	F	M	F	M	F
I. Infective and parasitic diseases	W		1		1	1		1	2									2		1	1	3	3	5	3	6	4			18	13	31					13	4
	C, A & B	22	29	9	10	5	11	36	50	3	3		1	6	6	11	7	23	15	41	13	26	7	18	3	6	3			170	108	278	40	7	48	35	72	43
II. Neoplasms	W			1		2		3		2	1		1	3		3	3	1	8	17	32	52	47	80	63	49	51			210	206	416					69	51
	C, A & B		1	1		1	3	2	4		2	3		6	4	7	4	26	26	98	45	101	55	86	40	27	21			356	201	557	45	12	56	28	108	51
III. Endocrine nutritional and metabolic diseases	W	1						1								1				2	1		4	7	8	2	8			13	21	34					3	5
	C, A & B	5	2	5	4	5	1	15	7					2	2		2	2	5	8	10	13	16	9	18	3	10			52	70	122	10	1	11	10	22	24
IV. Diseases of the blood and bloodforming organs	W																								1		1				1	1					1	1
	C, A & B										1																1				2	2					1	1
V. Mental disorders	W															1				1	1	1			1					3	2	5					1	1
	C, A & B															1		1		1			1		1					3	2	5					1	1
VI. Diseases of the nervous system and sense organs	W	1	2					1	2					1					1	2	1	3	3	3			2			10	9	19					1	4
	C, A & B	9	7	2	1	1	4	12	12	4	2		1	7	1	2	3	3		4	1	4		3	1					39	21	60	6	2	5	4	23	19
VII. Diseases of the circulatory system	W	1						1				1		2		8	3	20	3	61	24	110	44	179	135	115	155			497	364	861					111	71
	C, A & B	6	8	3	2		1	9	11	2	1	3	2	8	9	20	10	60	40	116	74	149	109	161	168	74	117			602	541	1 143	35	21	44	39	91	91
VIII. Diseases of the respiratory system	W	1	3	1	1	1		2	5					2		4		8	3	8	5	26	11	35	21	33	43			118	88	206					22	31
	C, A & B	74	77	18	25	9	9	101	111	6	6	5	2	11	11	29	16	48	27	82	31	78	38	61	21	17	16			438	279	717	50	28	84	43	90	34
IX. Diseases of the digestive system	W	1	1	1				2	1					2		1	2	4	1	5	3	8	2	6	5	3	1			31	15	46					14	8
	C, A & B	88	105	16	14	5	10	109	129	2	1			2	1	2	2	14	4	14	9	13	4	13	9	6	4			175	163	338	25	21	66	63	60	56
X. Diseases of the genito-urinary system	W													1					2		1	2	4	8	9	3	4			14	20	34					6	6
	C, A & B	3						3			2	1		2	2	4	1	4	4	10	7	6	4	7	8	1	6			38	34	72	8	2	3	4	13	14
XI. Complications of pregnancy, child-birth and the puerperium	W																																					
	C, A & B														2		5		2												9	9		2		1		2
XII. Diseases of the skin and subcutaneous tissue	W																																			2	1
	C, A & B																	1					1		1					2	1	3						
XIII. Diseases of the musculoskeletal system and connective tissue	W																																				1
	C, A & B														1										1					1	1	2					2	1
XIV. Congenital anomalies	W	5	2					5	2	1			1																	6	3	9					7	6
	C, A & B	15	12	1				16	12																1					17	12	29	3	1	1	2	18	5
XV. Certain causes of perinatal morbidity and mortality	W	7	4					7	4																					7	4	11					3	4
	C, A & B	97	84					97	84																					97	84	181	6	8	17	23	22	20
XVI. Symptoms and ill-defined conditions	W	3						3						1		2	1	4	2	5	10	14	2	25	17	30	26	80	213	164	271	435					24	26
	C, A & B	34	18	4	3	4	2	42	23		2			5	5	10	3	21	8	29	23	36	29	35	25	27	29	55	137	260	284	544	26	10	27	27	31	25
XVII. Accidents, poisonings and violence (external cause)	W					5	1	5	1		2	1		8	3	9	6	10	3	11	4	14	3	10	6	3	8	1	3	72	39	111					22	9
	C, A & B	4	7	5	2	8	4	17	13	16	8	21	6	105	22	86	13	55	14	42	6	21	5	10	1	1	3		1	374	92	466	70	6	64	20	72	9
TOTALS	W	20	13	3	2	8	2	31	17	3	3	2	2	20	3	29	15	49	23	113	83	233	123	358	269	244	302	81	216	1 163	1 056	2 219					299	231
	C, A & B	357	350	64	61	38	45	459	456	33	28	33	12	154	66	172	66	258	145	445	219	447	269	405	295	163	210	55	138	2 624	1 904	4 528	324	121	426	299	626	396
ALL RACES		377	363	67	63	46	47	490	473	36	31	35	14	174	69	201	81	307	168	558	302	680	392	763	564	407	512	136	354	3 787	2 960	6 747					925	627

W = White; C = Coloured; A = Asiatic; B = Blacks.

Table III.XVIII — *CORRECTED DEATHS BY OCCUPATION AT TIME OF DEATH, SEX AND VARIOUS AGE-GROUP INTERVALS : 1976*

OCCUPATION		AGE GROUP								NON-RESIDENTS	
		15—24		25—44		45—64		65 +			
	SEX	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B
Agriculture	M					1	1	1		14	1
	F										
Clerical	M	1	1	11	21	44	31	3	3	20	8
	F	1	5	6	4	13	3	2		4	
Domestic Servant	M										
	F		20		23		19		2		16
Fishing and Marine	M		2		7	2	6	1	1	6	7
	F										
Invalid	M	2	6	8	4	9	9	1	5	4	3
	F		3	5	3	6	2	5	1	1	6
Labourer	M		104	1	304	5	513		53	3	199
	F		4								
Managerial	M	1		4	1	26	4	19	2	16	1
	F					1		1			
Commercial	M			4	5	15	8	8	1	6	1
	F							1			
Professional	M			6	1	19	2	13		12	
	F			2		4	3		1	4	1
Police and Military	M			3		6				8	
	F										
Salesmen	M			6	3	17	14	2		6	5
	F		1		1	3		2			
Scholar	M	8	29	1							10
	F	2	9							3	5
Teacher	M				2	3	9			1	1
	F			1	2		2			1	2
Tradesmen	M	5	7	16	34	36	73	9	22	16	19
	F										
Transport	M			1	4	7	10	1	3	3	7
	F										
Other Workers	M	2	20	12	29	32	42	7	9	8	21
	F		15		15	4	11		1	2	9
Housewives	M										
	F		14	21	155	129	349	220	105	86	108
Retired etc.	M			5	12	126	172	618	524	150	94
	F			3	5	44	99	556	530	110	67
TOTAL	M	19	169	78	427	348	894	683	623	273	377
	F	3	71	38	208	204	488	787	640	211	214

W = White; C = Coloured; A = Asiatic; B = Blacks

Table III.XIX — *CORRECTED DEATHS BY MONTH OF REGISTRATION : 1971 TO 1976*

	1971	1972	1973	1974	1975	Mean Previous 5 years	1976
January	490	436	559	468	480	487	452
February	546	—	403	439	460	370	549
March	533	—	574	531	461	420	568
April	515	—	447	443	497	380	488
May	481	—	560	643	476	432	523
June	543	—	596	619	606	473	695
July	523	520	586	736	554	584	567
August	557	614	694	561	617	609	691
September	553	461	659	648	562	577	528
October	451	434	526	473	484	474	515
November	448	579	495	559	582	533	615
December	401	429	545	488	413	455	556
TOTAL	6 041	3 473	6 644	6 608	6 192	5 792	6 747
MEAN	503	496	554	551	516	524	562
Per 1 000 population	8,2	7,9	8,6	8,3	7,6	8,1	8,0

Table III.XX *THE TEN PRINCIPAL CAUSES OF MORTALITY IN CAPE TOWN : 1976 (BEING ARBITRARILY GROUPED CONDITIONS BASED ON THE INTERNATIONAL CLASSIFICATION OF DISEASES, 8th REVISION, AND EXCLUDING ILL-DEFINED CAUSES*

WHITES				COLOURED, ASIATIC AND BLACKS			
Int. Code No.	Cause of death	Deaths	Death rate	Int. Code No.	Cause of death	Deaths	Death rate
393—398 402, 404 410—414 420—429	Cardiovascular diseases	605	2,39	393—398 402, 404 410—414 420—429	Cardiovascular diseases	671	1,14
140—209	Cancer	410	1,62	466 480—486 490—491	Bronchitis and Pneumonia	573	0,97
794	Senility	304	1,20				
430—438 440—448	Arterial diseases	231	0,91	140—209	Cancer	548	0,93
466 480—486 490—491	Bronchitis and Pneumonia	133	0,52	E800—999	Accidents and violence	466	0,79
				430—438 440—448	Arterial diseases	415	0,70
E800—999	Accidents and violence	111	0,44	561	Gastro Enteritis	247	0,42
492—3 500—519 470—4, 460—5 467	Other Respiratory diseases	72.	0,28	794	Senility	210	0,36
580—629	Diseases of Genito/ Urinary System	34	0,13	771—9	Peri Natal Mortality	175	0,30
250	Diabetes Mellitus	29	0,11	010—019	Tuberculosis	164	0,28
390—2, 400—1 403—4 450—8	Other diseases of Circulatory System	28	0,11	492—3 500—519 470—4, 460—5 467	Other Respiratory diseases	143	0,24

Table III.XXI *DEATHS FROM 'CANCER' (MALIGNANT NEOPLASMS INCLUDING THOSE OF LYMPHATIC AND HAEMOPOETIC TISSUE) AND DEATH RATES PER 100 000 POPULATION : 1976*

Int. Code No.	Parts affected	White		Coloured, Asiatic & Blacks		Total	
		Deaths	Rate	Deaths	Rate	Deaths	Rate
140—9	Malignant neoplasm of buccal cavity and pharynx	11	4	17	3	28	3
150	Malignant neoplasm of oesophagus	11	4	65	11	76	9
151	Malignant neoplasm of stomach	29	11	80	14	109	13
152—3	Malignant neoplasm of intestine	38	15	14	2	52	6
154	Malignant neoplasm of rectum	11	4	11	2	22	3
155	Malignant neoplasm of liver	6	2	18	3	24	3
157	Malignant neoplasm of pancreas	16	6	16	2	32	4
162	Malignant neoplasm of trachea and bronchus of lung	84	33	112	19	196	23
174	Malignant neoplasm of breast	42	17	37	6	79	9
180	Malignant neoplasm of cervix uteri	8	3	20	3	28	3
183	Malignant neoplasm of ovary	6	2	8	1	14	2
185	Malignant neoplasm of prostate	16	6	12	2	28	3
188	Malignant neoplasm of bladder	11	4	6	1	17	2
200—9	Neoplasm of lymphatic and haemotopoietic tissues	46	18	31	5	77	9
	Malignant neoplasm of other and unspecified sites	75	30	101	17	176	21
	TOTAL	410	162	548	93	958	114

Table III.XXII — *LUNG CANCER MORTALITY OVER A SERIES OF YEARS*

YEAR	Whites		Rates per 100 000 population		Coloured, Asiatic and Blacks		Rates per 100 000 population	
	Male	Female	Male	Female	Male	Female	Male	Female
1947	21	3	23,5	3,1	4	2	4,1	2,0
1957	46	6	49,8	5,9	27	5	17,0	3,0
1967	57	7	57,1	6,4	51	8	22,9	3,7
1971	53	17	47,3	13,8	54	10	21,3	4,1
1973	58	23	50,2	18,1	83	13	31,1	5,0
1974	60	22	51,2	17,0	79	16	28,5	5,9
1975	61	29	51,3	22,1	86	17	30,1	6,0
1976	61	23	50,3	17,3	88	24	29,8	8,2

Table III.XXIII — *PERCENTAGE OF PERSONS DYING OF LUNG CANCER UNDER THE AGE OF 55 YEARS AND AT OR OVER THE AGE OF 55 YEARS : 1972 – 1976*

	WHITE		COLOURED, ASIATIC AND BLACKS	
	Under 55 years %	Over 55 years %	Under 55 years %	Over 55 years %
1972	18	82	38	62
1973	24	76	43	57
1974	7	93	35	65
1975	18	82	42	58
1976	13	87	31	69

Table III.XXIV

SELECTED CAUSES OF DEATH BY RACE : 1976

International Cod INTERNATIONAL CODE NO.	CAUSE OF DEATH	WHITE	COLOURED	ASIATIC	BLACKS	TOTAL
001	Typhoid	—	—	—	—	—
004,8.9.561	Dysentery and Gastro Enteritis	3	93	1	165	262
011	Tuberculosis Pulmonary	3	71	—	74	148
010,012—019	Other Forms	1	6	—	13	20
032	Diphtheria	—	—	—	1	1
033	Whooping Cough	—	—	—	—	
036	Meningococcal Infections	3	16	—	4	23
038	Septicaemia	20	24	—	7	51
040—043	Acute Poliomyelitis	—	—	—	—	
055	Measles	—	11	—	23	34
070	Viral Hepatitis	—	2	—	1	3
090—097	Syphilis	—	1	—	2	3
	Other Infective and Parasitic Diseases	—	—	—	—	
140—209	Malignant Neoplasms	410	403	3	142	958
210—239	Benign Neoplasms	6	5	—	4	15
250	Diabetes Mellitus	29	70	4	15	118
280—289	Anemias	1	2	—	—	3
320—358	Diseases of Nervous System	19	39	1	19	78
390—392	Rheumatic Fever	—	—	—	—	
393—398	Heart Disease Rheumatic	5	11	—	4	20
410—414	Degenerative	471	348	17	23	859
420—429	Other	117	180	4	33	334
430—438	Cerebrovascular Diseases	208	316	7	61	592
440—448	Diseases of Arteries	23	26	1	4	54
470—474	Influenza	1	2	—	1	4
480—486	Pneumonia	126	364	1	185	676
466,490—491	Bronchitis	7	15	—	8	30
500—519	Other Diseases of Respiratory System	45	69	—	16	130
531—532	Ulcer of Stomach and Duodenum	2	4	—	—	6
540	Acute Appendicitis	1	—	—	—	1
550—560	Intestinal Obstruction and Hernia	1	5	—	1	7
571	Cirrhosis of Liver	2	6	—	—	8
580—584	Nephritis	6	8	—	4	18
590—629	Other Diseases of Genito-Urinary System	28	46	1	13	88
630—678	Complications of Pregnancy	—	5	—	4	9
740—759	Congenital Anomalies	9	19	2	8	38
760—779	Perinatal Mortality	11	119	—	62	192
780—796	Senility and Ill Defined	435	446	4	94	979
810—819	Motor Vehicle Accidents	17	112	1	48	178
	All Other Accidents	—	—	—	—	—
950—959	Suicide	34	14	—	4	52
960—977	Homicide	6	45	—	81	132
	Other Causes	169	328	3	123	623
	TOTAL	2 219	3 231	50	1 247	6 747

Table III.XXIV

Table III.XXV SELECTED CAUSES OF DEATH BY MONTH OF REGISTRATION : 1976

International Code No.	DISEASE	White, Coloured, Asiatic and Blacks	January	February	March	April	May	June	July	August	September	October	November	December	Year
001, 002	Typhoid	W													
		C, A & B													
010—	Tuberculosis	W			1									2	3
012	Pulmonary	C, A & B	11	14	11	12	18	13	14	12	10	19	7	5	146
013—	Tuberculosis	W								1					1
019	Other Forms	C, A & B	1	1	1	2		2	1		1	4	3	2	18
032	Diphtheria	W													
		C, A & B			1										1
033	Whooping Cough	W													
		C, A & B													
036	Meningococcal Infections	W								1		1		1	3
		C, A & B		1	1	2	3		5	2	2	1		3	20
040— 044	Poliomyelitis	W													
		C, A & B													
055	Measles	W													
		C, A & B	1		1	3	9	5	7	3	3	1		1	34
090— 099	Veneral Disease	W													
		C, A & B		1			1						1		3
140— 209	Malignant Neoplasms	W	42	38	37	26	27	38	29	31	33	24	50	35	410
		C, A & B	45	51	46	42	38	53	38	44	49	41	57	44	548
250	Diabetes	W	3	3	1	1			1	5	4	4	5	2	29
		C, A & B	10	9	7	1	2	8	10	4	14	7	8	9	89
390— 392	Rheumatic Fever	W													
		C, A & B													
393— 398	Rheumatic Heart	W	1	1	1				1					1	5
		C, A & B	1	3	3		2				1		2	3	15
400— 404	Hypertension	W	2	2	3	2		2		4		1	1	3	20
		C, A & B	12	18	1	2	1	2	7	13	9	7	8	9	89
410— 414	Ischaemic Heart Disease	W	37	27	47	27	21	38	41	64	35	46	44	44	471
		C, A & B	33	26	18	23	26	43	40	44	34	40	40	21	388
420— 429	Other Heart Diseases	W	5	7	6	11	8	17	13	15	11	7	13	4	117
		C, A & B	9	12	7	15	14	38	35	27	14	15	16	15	217
430— 438	Cerebrovascular Diseases	W	16	15	29	10	17	15	19	17	19	11	16	24	208
		C, A & B	26	30	20	35	38	41	28	49	27	33	34	23	384
440— 448	Arterial Diseases	W	1		3	1	2	2	2	2	3	4		3	23
		C, A & B	1		1	2	1	3	3	4	8	4	1	3	31
470— 474	Influenza	W							1						1
		C, A & B				1	1	1							3
480—6	Pneumonia	W	9	8	11	7	8	21	8	15	12	6	13	8	126
		C, A & B	29	43	36	35	54	71	62	78	34	32	41	35	550
466, 490—1	Bronchitis	W	1		1					2		2	1		7
		C, A & B		5		1	1	1	1	3	4	2	4	1	23
004,8,9 561	Gastro Enteritis	W				1		1					1		3
		C, A & B	17	44	35	40	31	24	16	5	10	9	12	17	260
580— 584	Nephritis	W								1	2		1	2	6
		C, A & B			1	1		1		6	1	1		1	12
630—9 650—678	Pregnancy	W													
		C, A & B									1				1
640—5	Abortion	W													
		C, A & B		1		2			1	3	1				8
740— 759	Congenital Anomalies	W	1			1		3		1			1	2	9
		C, A & B	2	5	3	1		3	1	3	3	4	3	1	29
770— 779	Perinatal Mortality	W	1	2		1	1	1		1		1	1	2	11
		C, A & B	11	15	18	8	10	18	19	16	16	13	12	20	176
780— 796	Ill Defined & Senility	W	28	31	34	33	33	51	45	38	28	41	34	39	435
		C, A & B	25	39	34	55	47	72	50	51	36	50	49	36	544
800—7	Railway Accidents	W				1							1		2
		C, A & B		1	3	1	4	2		4	3	4	1	2	25
810—827	Road Accidents	W	2	3	1	1	4	2		1	1		3	5	23
		C, A & B	9	14	24	11	18	9	8	20	13	9	20	15	170
830—949	Other Accidents	W	4	4	5	4	1	5	2	3	7	1	9		45
		C, A & B	4	14	16	10	13	3	3	17	5	6	17	15	123
950—959	Suicide	W	2	1	4	1	5	3		3	6	1	3	5	34
		C, A & B		1	2		2		2	2	2	1	4	2	18
960—999	Homicide	W		1	1		1		1		1	1	1		7
		C, A & B	5	14	14	7	7	2	4	13	2	8	15	38	129
	ALL CAUSES	W	165	159	213	141	141	228	183	220	183	164	224	199	2 220
		C, A & B	287	390	356	347	382	467	384	472	345	351	391	357	4 529

W = White; C = Coloured; A = Asiatic; B = Blacks.

Table III.XXVI

DEATH RATES BY SELECTED CAUSE AND RACE GROUP : 1966 – 1976

DISEASE	RACE	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	Mean Previous 10 Yrs	1976
Enteric Fever	W												
	C, A & B	0,01		0,00			0,00				0,00	0,00	
Gastro-enteritis and colitis, except ulcerative (including diarrhoea of the newborn)	W	0,03	0,02	0,02	0,01	0,04	0,01	0,01	0,00	0,02	0,01	0,02	0,01
	C, A & B	0,88	0,80	0,69	0,76	0,85	0,63	0,43	0,59	0,49	0,38	0,65	0,44
Tuberculosis, respiratory system	W	0,05	0,03	0,04	0,03	0,04	0,02	0,05	0,03	0,02	0,00	0,03	0,01
	C, A & B	0,34	0,45	0,39	0,40	0,38	0,31	0,38	0,35	0,28	0,27	0,36	0,25
Tuberculosis, other forms	W	0,01			0,00	0,01				0,01		0,00	0,00
	C, A & B	0,07	0,05	0,05	0,05	0,03	0,03	0,03	0,04	0,05	0,02	0,04	0,03
Diphtheria	W										0,01	0,00	
	C, A & B	0,00			0,00			0,00		0,00	0,00	0,00	0,00
Whooping cough	W												
	C, A & B	0,01	0,00	0,01		0,01	0,00	0,01	0,00	0,01		0,01	
Meningococcal cerebrospinal meningitis	W	0,00		0,01		0,00			0,00			0,00	0,01
	C, A & B	0,03	0,07	0,02	0,02	0,01	0,01	0,02	0,01	0,00	0,01	0,02	0,03
Purulent infection — septicaemia, and erysipelas (non-puerperal)	W	0,02	0,02	0,02	0,03	0,03	0,00	0,01	0,06	0,06	0,03	0,03	0,08
	C, A & B	0,03	0,04	0,04	0,01	0,03	0,03	0,05	0,08	0,11	0,07	0,05	0,05
Acute anterior poliomyelitis and polioencephalitis	W		0,00									0,00	
	C, A & B			0,00								0,00	0,00
Measles	W	0,00	0,00		0,01	0,00		0,01	0,00		0,00	0,00	0,00
	C, A & B	0,11	0,08	0,09	0,12	0,09	0,11	0,06	0,09	0,13	0,05	0,09	0,06
Acute infectious encephalitis	W					0,01						0,00	
	C, A & B	0,01	0,01	0,00	0,01	0,00			0,00			0,00	0,00
Syphilis	W	0,01	0,01	0,00	0,00		0,00		0,00			0,00	
	C, A & B	0,00	0,02	0,02	0,02	0,02	0,01	0,01	0,02	0,01	0,01	0,01	0,00
General paralysis of the insane: tabes dorsalis	W	0,00		0,01		0,00		0,01				0,00	
	C, A & B	0,01	0,02	0,01	0,01	0,01	0,00	0,01	0,00	0,02	0,00	0,01	0,00
Cancer	W	1,72	1,79	1,74	1,90	1,73	1,65	1,70	1,77	1,77	1,68	1,75	1,62
	C, A & B	0,79	0,80	0,84	0,88	0,88	0,82	0,92	0,97	0,89	0,91	0,87	0,93
Diabetes	W	0,15	0,14	0,18	0,33	0,40	0,33	0,32	0,09	0,06	0,05	0,21	0,11
	C, A & B	0,13	0,14	0,16	0,23	0,35	0,23	0,30	0,16	0,14	0,09	0,19	0,15
Acute rheumatic fever	W		0,01							0,00		0,00	
	C, A & B	0,01	0,02	0,01	0,02	0,01	0,00	0,01	0,01	0,01	0,01	0,01	
Cardiac diseases	W	2,92	2,92	2,98	2,74	2,82	2,35	2,05	2,88	2,63	2,30	2,66	2,42
	C, A & B	1,30	1,35	1,34	1,15	1,22	1,02	0,72	1,33	1,10	1,01	1,15	1,20
Intracranial lesions of vascular origin	W	1,49	1,23	1,29	1,02	1,16	0,97	1,06	1,02	0,92	0,80	1,10	0,82
	C, A & B	0,78	0,86	0,80	0,72	0,77	0,62	0,66	0,73	0,74	1,03	0,77	0,65
Arterio sclerosis	W	0,25	0,10	0,07	0,09	0,11	0,06	0,01	0,08	0,11	0,12	0,10	0,01
	C, A & B	0,08	0,07	0,06	0,02	0,04	0,04	0,04	0,02	0,05	0,04	0,05	0,01
Aneurysm of the aorta	W								0,02			0,00	0,06
	C, A & B					0,00			0,01	0,00	0,00	0,00	0,02
Influenza	W		0,00			0,00				0,02		0,00	0,00
	C, A & B	0,01	0,01	0,00	0,02	0,01		0,00	0,01	0,02	0,00	0,01	0,01
Bronchitis and pneumonia (including pneumonia of the newborn)	W	0,27	0,31	0,25	0,34	0,41	0,38	0,45	0,43	0,37	0,48	0,37	0,52
	C, A & B	0,83	0,88	0,87	0,94	1,00	0,86	0,86	0,94	0,84	0,75	0,88	0,97
Nephritis	W	0,06	0,09	0,08	0,11	0,11	0,11	0,06	0,05	0,03		0,07	0,02
	C, A & B	0,07	0,08	0,13	0,10	0,07	0,08	0,08	0,07	0,04	0,02	0,07	0,02
Puerperal sepsis	W	0,00										0,00	
	C, A & B	0,02	0,02	0,01	0,00	0,01	0,01	0,00	0,00	0,00		0,01	
Other diseases of pregnancy, childbirth and puerperal state	W	0,00			0,00	0,00						0,00	
	C, A & B	0,03	0,04	0,02	0,01	0,02	0,02	0,01	0,00	0,01	0,01	0,02	0,02
Congenital malformations and diseases of early infancy	W	0,24	0,21	0,25	0,30	0,23	0,20	0,19	0,16	0,14	0,12	0,20	0,08
	C, A & B	1,18	1,09	0,99	0,97	0,90	0,76	0,56	0,59	0,49	0,40	0,79	0,35
Senility	W	1,46	1,50	1,55	1,51	1,59	1,61	1,50	1,44	1,26	1,46	1,49	1,20
	C, A & B	0,36	0,63	0,34	0,39	0,45	0,49	0,31	0,44	0,30	0,65	0,44	0,34
Accidents, poisonings and violence (external cause)	W	0,52	0,57	0,42	0,57	0,57	0,37	0,31	0,45	0,32	0,44	0,45	0,44
	C, A & B	1,02	1,07	0,89	1,07	1,14	0,94	0,57	0,90	0,57	0,79	0,90	0,79
Other causes	W	1,24	1,05	1,26	1,32	1,33	0,90	1,23	1,01	1,30	0,95	1,16	1,33
	C, A & B	1,71	1,31	1,51	1,40	1,32	0,72	1,36	1,58	1,67	1.02	1,36	1,33
TOTAL	W	10,46	10,03	10,19	10,34	10,57	9,04	8,99	9,40	9,05	8,44	9,65	8,75
	C, A & B	9,76	9,91	9,31	9,34	9,62	7,82	7,41	8,26	7,98	7,18	8,66	7,69

W = White; C = Coloured; A = Asiatic; B = Blacks

Table III.XXVII *DEATHS AND DEATH RATES IN WHITES AND COLOUREDS DUE TO CORONARY THROMBOSIS (ICD CODE NO. 410) : 1972 – 1976*

RACE	1972		1973		1974		1975		1976	
	M	F	M	F	M	F	M	F	M	F
White	159 (273)	111 (190)	346	209	258	184	261	132	249	156
	2,40	1,52	3,00	1,64	2,20	1,43	2,20	1,01	2,06	1,17
Coloured	96 (165)	69 (118)	193	128	166	97	131	97	173	113
	0,85	0,54	0,96	0,56	0,80	0,41	0,61	0,40	0,77	0,45

Table III.XXVIII *DEATHS AND DEATH RATES DUE TO MEASLES BY RACE GROUP : 1967 – 1976*

YEAR	MEASLES			
	Deaths		Rate per 100 000 population	
	White	Coloured, Asiatic and Black	White	Coloured, Asiatic and Black
1967	1	36	0,48	8,16
1968		42		9,44
1969	2	54	0,93	11,69
1970	1	43	0,46	9,01
1971		55		11,00
1972	1(2)	19(33)	0,84	6,43
1973	1	49	0,41	9,23
1974		69		12,56
1975	1	26	0,40	4,57
1976		34		5,77

Table III.XXIX *DEATHS AND DEATH RATES DUE TO INFLUENZA (ICD CODE 470 – 474) BRONCHITIS (ICD CODE NO. 466, 490 – 491) AND PNEUMONIA (ICD CODE NOS. 480 – 486) BY RACE GROUP : 1967 – 1976*

YEAR	INFLUENZA				BRONCHITIS				PNEUMONIA (all forms)			
	White		Coloured Asiatic and Black		White		Coloured Asiatic and Black		White		Coloured Asiatic and Black	
	No	Rate per 100 000	No.	Rate per 100 000	No.	Rate per 100 000	No.	Rate per 100 000	No.	Rate per 100 000	No.	Rate per 100 000
1967	1	0,48	3	0,68	37	17,65	69	15,64	29	13,83	320	72,54
1968			2	0,45	25	11,79	75	16,86	27	12,73	283	63,61
1969			9	1,95	45	20,98	90	19,48	29	13,52	346	74,89
1970	1	0,46	5	1,05	50	23,04	114	23,89	39	17,97	361	75,65
1971					45	19,10	107	21,39	44	18,68	321	64,17
1972			1(2)	0,39	34(58)	24,26	50(86)	16,75	29(50)	20,92	207(354)	68,95
1973			6	1,14	21	8,66	53	10,03	83	34,21	419	79,33
1974	4	1,62	13	2,37	6	2,44	33	6,01	84	34,12	429	78,12
1975			2	0,35	3	1,20	25	4,40	116	46,43	404	71,03
1976	1	0,39	3	0,51	7	2,76	23	3,90	126	49,69	550	93,37

Table III.XXX *DEATHS DUE TO BRONCHITIS (ICD CODE 466, 490, 491) AND PNEUMONIA (ICD CODE 480–486) BY RACE AND AGE : 1975 – 1976*

	1975		1976	
	White	Coloured, Asiatic and Black	White	Coloured, Asiatic and Black
Under 1 year	7	125	4	147
1 — 2 years	1	15	2	40
3 — 4 years		12	1	17
Total under 5 years	8	152	7	204
All other ages	111	277	126	369
TOTAL	119	429	133	573

Table III.XXXI — *DEATHS AND DEATH RATES DUE TO THE GROUP OF DIARRHOEAL DISEASES SHOWN : 1967 – 1976*

INT. CODE NO.	DISEASE	1967			1968			1969			1970			1971		
		W	C, A & B	T	W	C, A & B	T	W	C, A & B	T	W	C, A & B	T	W	C, A & B	T
561	Gastro-enteritis and colitis, including diarrhoea of the newborn	4	355	359	5	309	314	3	351	354	8	405	413	3	315	318
563	Chronic enteritis and ulcerative colitis	2	1	3	1	3	4	3	2	5	2		2	2	2	4
000	Cholera															
004	Dysentery, bacillary		1	1		1	1		1	1						
006	Dysentery, amoebic		6	6		4	4		4	4		5	5		2	2
007—9	Dysentery, other forms											1	1			
	TOTAL	6	363	369	6	317	323	6	358	364	10	411	421	5	319	324
	Diarrhoeal death rate per 100 000 population	2,86	82,29	56,70	2,83	71,25	49,16	2,80	77,49	53,80	4,61	86,13	60,64	2,12	63,77	44,04

		1972			1973			1974			1975			1976		
561	Gastro-enteritis and colitis, including diarrhoea of the newborn	2(3)	129(221)	131(224)	1	312	313	5	268	273	2	199	201	1	247	248
563	Chronic enteritis and ulcerative colitis		2(3)	2(3)	2	1	3					2	2	2		2
000	Cholera															
004	Dysentery, bacillary					1	1		2	2				1		1
006	Dysentery, amoebic					6	6		2	2		2	2		3	3
007—9	Dysentery, other forms					1	1	1	1	2		8	8	1	9	10
	TOTAL	2(3)	131(224)	133(227)	3	321	324	6	273	279	2	211	213	5	259	264
	Diarrhoeal death rate per 100 000 population	1,25	43,63	30,17	1,24	60,77	42,04	2,44	49,71	35,08	0,80	37,10	26,02	1,97	43,97	31,33

Table III.XXXII *DEATHS OF INFANTS UNDER THE AGE OF ONE YEAR DUE TO DIARRHOEA AND GASTRO-ENTERITIS BY RACE GROUP : 1967 – 1976*

YEAR	DIARRHOEA AND ENTERITIS					
	White		Coloured, Asiatic and Black		All Races	
	Male	Female	Male	Female	Male	Female
1967	1	2	149	134	150	136
1968	1	2	115	126	116	128
1969	2	1	155	124	157	125
1970	4	1	161	173	165	174
1971	3	1	124	123	127	124
1972			58(99)	47(81)	58(99)	47(81)
1973		1	113	102	113	103
1974			102	99	102	99
1975	1		97	97	98	97
1976	1		105	129	106	129

Table III.XXXIII *DEATHS DUE TO HOME ACCIDENTS BY CAUSE, SEX, AGE GROUP AND RACE GROUP : 1976*

CAUSE	SEX	AGE GROUPS														
		0—4		5—14		15—24		25—49		50—64		65 +		TOTAL		
		W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	T
Burns or Scalding	M		1		4		2		1		3		1		12	12
	F		2		2				1		1				6	6
Falls	M		2					1		1	1	2	1	4	4	8
	F				1			1		1		8	1	10	2	12
Suffocation	M		1									1		1	1	2
	F		2					1						1	2	3
Poisoning by drugs	M												1		1	1
	F															
Carbon Monoxide Poisoning	M						2		1	1		1		2	3	5
	F						1	1						1	1	2
Drowning	M															
	F		2				1								3	3
Cuts	M															
	F															
Electrocution	M															
	F															
Firearms	M															
	F															
Other	M		2												2	2
	F		1												1	1
TOTAL	M		6		4		4	1	2	2	4	4	3	7	23	30
	F		7		3		2	3	1	1	1	8	1	12	15	27
	T		13		7		6	4	3	3	5	12	4	19	38	57

W – White; C = Coloured; A = Asiatic; B = Black

Table III.XXXIV *ACCIDENTAL DEATHS BY CAUSE : 1972 – 1976*

	1972	1973	1974	1975	1976
Railway	8(14)	15	6	25	27
Road Traffic	101(173)	202	148	174	194
Poisoning	5(9)	11	16	15	23
Falls	10(17)	24	32	59	45
Drowning	15(26)	31	20	44	41
Asphyxia	1(2)	3	1	10	5
Burns	6(10)	24	26	20	24
Trauma	2(3)	19	8	3	
Firearms		1	2		2
Electrocution	1(2)	1	1	2	2
Miscellaneous	8(14)	32	31	27	25
TOTAL	157(269)	363	291	379	388

Tables III.XXXV : III.XXXVI : III.XXXVII : III.XXXVIII

Table III.XXXV *SUICIDAL DEATHS BY RACE AND SEX : 1972 – 1976*

YEAR	White		Coloured, Asiatic and Blacks		Total			Rate per 1 000
	Male	Female	Male	Female	Male	Female	Persons	
1972	5(9)	5(9)	7(12)		12(21)	5(9)	17(30)	0,04
1973	19	16	13	4	32	20	52	0,07
1974	12	3	14	1	26	4	30	0,04
1975	17	10	16	6	33	16	49	0,06
1976	25	9	16	2	41	11	52	0,06

Table III.XXXVI *SUICIDAL DEATHS BY AGE GROUP AND RACE : 1972 – 1976*

YEAR	10—14		15—24		25—44		45—64		65 +		Total
	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	
1972	—	—	—	1(2)	6(10)	4(7)	2(3)	2(3)	2(3)	—	17(30)
1973	—	—	5	4	11	11	9	2	10	—	52
1974	—	—	3	3	6	9	6	3	—	—	30
1975	—	—	5	5	9	10	7	9	4	—	49
1976	1	—	5	4	11	10	12	4	5	—	52

Table III.XXXVII *SUICIDAL DEATHS BY METHOD ADOPTED : 1972 – 1976*

	1972	1973	1974	1975	1976
Drug Poisoning	6(10)	28	4	9	8
Hanging	7(12)	5	9	15	15
Firearms	2(3)	4	10	11	12
Carbon monoxide Poisoning	1(2)	3	2	2	7
Falls	—	4	—	4	4
Railway	1(2)	3	2	1	4
Drowning	—	1	—	3	—
Wounds	—	1	1	2	—
Electrocution	—	1	—	—	—
Burns	—	1	—	2	2
Inanition	—	1	—	—	—
Suffocation	—	—	2	—	—

Table III.XXXVIII *NUMBERS AND PERCENTAGES OF TOTAL UNCORRECTED AND CORRECTED DEATHS OCCURRING IN INSTITUTIONS BY RACE : 1976*

RACE	UNCORRECTED		CORRECTED	
	Deaths in institutions	Percentage of total deaths	Deaths in institutions	Percentage of total deaths
White	1 802	66	1 310	59
Coloured	2 312	58	1 556	48
Asiatic	26	49	23	46
Blacks	949	64	713	57
TOTAL	5 089	61	3 602	53

Table III.XXXIX *DEATHS OF INFANTS UNDER ONE YEAR AND INFANT MORTALITY RATES BY RACE AND SEX : 1975 – 1976*

RACE	INFANT DEATHS						RATE PER 1 000 LIVE BIRTHS					
	1975			1976			1975			1976		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
White	31	9	40	20	13	33	18,7	5,5	12,2	12,6	8,1	10,4
Coloured	210	187	397	199	182	381	33,0	31,3	32,2	32,5	30,6	31,6
Asiatic	2		2	1		1	17,2		8,3	6,8		3,8
Blacks	130	108	238	157	168	325	64,8	53,4	59,0	76,0	82,0	79,0
TOTAL	373	304	677	377	363	740	36,8	31,2	34,0	38,0	37,4	37,7

Table III.XXXIX

Table III.XL *INFANT DEATHS AND INFANT MORTALITY RATES BY RACE : 1972 – 1976*

RACE	1972		1973		1974		1975		1976	
	Deaths under 1 year	Infant mortality rate	Deaths under 1 year	Infant mortality rate	Deaths under 1 year	Infant mortality rate	Deaths under 1 year	Infant mortality rate	Deaths under 1 year	Infant mortality rate
White	31(53)	13,0	48	12,7	43	12,0	40	12,2	33	10,4
Coloured	296(507)	35,8	562	39,9	526	38,9	397	32,2	381	31,6
Asiatic	2(3)	16,5	7	28,0	7	29,1	2	8,3	1	3,8
Blacks	103(177)	48,1	268	68,2	292	68,7	238	59,0	325	79,0
ALL RACES	432(740)	33,5	885	40,2	868	40,2	677	34,0	740	37,7

Table III.XLI

DEATHS OF INFANTS UNDER ONE YEAR OF AGE BY SELECTED CAUSES AND AGES : 1976

International Code No.	DISEASE	RACE	DAYS							Total under 1 week	WEEKS			Total under 4 weeks	MONTHS											TOTAL under one year			Bantu Townships Included in foregoing columns					
			<1	1	2	3	4	5	6		1	2	3		1	2	3	4	5	6	7	8	9	10	11				LANGA			GUGULETU		
																										M	F	Persons	M	F	Persons	M	F	Persons
004,8,9 561	Diarrhoea and enteritis	W											1	1												1		1						
		C, A & B		1			2	2		5	4	2	1	12	16	26	27	34	13	20	12	7	11	7	5	84	106	190	18	14	32	45	46	91
010—012 014—019	Tuberculosis, Pulmonary and other forms	W																																
		C, A & B														1			2	1	1					2	3	5				2	3	5
013	Tuberculosis, meningeal	W																																
		C, A & B																1							1	1	1	2				1		1
032	Diphtheria	W																																
		C, A & B																																
033	Whooping cough	W																																
		C, A & B																																
038	Septicaemia	W																																
		C, A & B	1		2	2		1		6	1		1	8	2		2									6	6	12				1	2	3
055/6	Measles and Rubella	W										1		1													1	1						
		C, A & B														1		1	1	2	3	1		5	3	7	10	17	2		2	5	7	12
090	Syphillis, congenital	W																																
		C, A & B		1						1	1			2												1	1	2	1		1		1	1
259—266	Avitaminosis	W																																
		C, A & B																					1			1		1				1		1
267—273	Nutritional Maladjustment	W													1											1		1						
		C, A & B													1	1		1	1			1		1		4	2	6				1		1
320	Simple meningitis	W																																
		C, A & B		1		1		1		3			1	4	1		2	1	2		1		2			7	6	13		1	1	2	2	4
466, 490—1	Bronchitis	W																																
		C, A & B										1	2	3	2	1					1			1	1	5	3	8		1	1	3	1	4
480—6	Pneumonia (all forms)	W													1	1	1							1		1	3	4						
		C, A & B	1	1	1	2		2		7	6	1	3	17	10	19	23	10	13	11	6	8	6	9	7	65	74	139	7	15	22	18	14	32
500—519	Postnatal Asphyxia and Atelectasis	W																																
		C, A & B	1	1						2			1	3		2										4	1	5				1		1
740—759	Congenital Anomalies	W				1	1	1		3	1			4	2						1					5	2	7						
		C, A & B	4	2	2	2			1	11	2	2	4	19	3	1	1	1		1				1	1	16	12	28	2	1	3	1	2	3
772	Injury at birth	W																																
		C, A & B	1		1					2				2													2	2				1		1
774/5	Haemolytic Diseases of new born	W	1							1				1													1	1						
		C, A & B																																
776, 8	Other Diseases peculiar to early infancy	W																																
		C, A & B	18	7	4	1	1	1		32	1	1	1	35		1										21	15	36	2	2	4	6	4	10
777	Prematurity	W	4	1	2	1	1	1		10				10												7	3	10						
		C, A & B	59	27	13	7	1	5	2	114	10	4	2	130	4	1										70	65	135	4	6	10	11	17	28
E913	Accidental mechanical suffocation	W																																
		C, A & B				1				1				1													1	1		1	1			
	Other and ill-defined or unknown causes	W						1		1	1	1		3	3	1						1				5	3	8						
		C, A & B	11	4	4	1		2		22	4	5		31	8	7	13	9	5	4	7	4	3	6	8	63	42	105	11	7	18	7	8	15
	TOTALS	W	5	1	2	2	2	3		15	2	2	1	20	7	2	1				1	1		1		20	13	33						
		C, A & B	96	45	27	17	4	14	3	206	29	16	16	267	47	61	68	58	37	39	31	21	23	29	26	357	350	707	47	48	95	105	108	213

W = White; C = Coloured; A = Asiatic; B = Blacks

Table III.XLII — *NEO-NATAL, POST NEO-NATAL AND INFANT MORTALITY RATES FOR SELECTED CAUSES OF DEATH : 1976*

Cause of death	Neo-natal mortality rate		Post neo-natal mortality rate		Infant mortality rate	
	White	Coloured Asiatic and Blacks	White	Coloured Asiatic and Blacks	White	Coloured Asiatic and Blacks
Whooping cough						
Tuberculosis (all forms)				0,4		0,4
Scarlet fever						
Measles	0,3			1,0	0,3	1,0
Diphtheria						
Syphilis		0,1		0,1		0,1
Bronchitis and pneumonia		1,2	1,3	7,7	1,3	8,9
Gastro enteritis	0,3	0,7		10,8	0,3	11,5
Prematurity	3,1	7,9		0,3	3,1	8,2
Injury at birth		0,1				0,1
Congenital malformations	1,3	1,2	0,9	0,5	2,2	1,7
Other diseases of early infancy	0,3	2,4	0,3	0,5	0,6	2,9
Other and ill-defined or unknown causes	0,9	2,7	1,6	5,3	2,5	8,0
TOTAL	6,3	16,2	4,1	26,7	10,4	43,0

Table III.XLIII — *INFANT MORTALITY RATES FOR SELECTED CAUSES OF DEATH : 1967 – 1976*

Cause of death	1967	1968*	1969*	1970*	1971*	1972*	1973*	1974*	1975*	1976*
WHITE										
Whooping cough										
Tuberculosis										
Measles										
Diphtheria										
Syphilis	0,3		0,3							
Bronchitis and pneumonia	0,8	1,3	1,5	1,2	1,9	0,7		0,8	2,1	1,3
Gastro enteritis	0,8	0,5	0,8	1,2	0,7		0,3			0,3
Prematurity	2,1	2,4	4,6	1,9	3,0	2,4	3,4	3,9	3,6	3,1
Injury at birth	0,5	1,3	1,0	1,2	0,5	0,5	0,5	0,3		
Congenital malformations	3,7	3,7	3,3	3,4	2,3	2,4	2,6	3,3	3,6	2,2
Other diseases of early infancy	4,5	4,4	4,8	3,8	3,3	4,6		1,4	1,2	0,6
Other causes	2,1	1,3	1,3	3,1	1,2	2,2	5,8	2,2	1,5	2,5
ALL CAUSES	15	15	18	16	13	13	13	12	12	10
COLOURED, ASIATIC AND BLACKS										
Whooping cough	0,1	0,2		0,1	0,1	0,1	0,1	0,2		
Tuberculosis	0,9	0,3	0,5	0,2	0,3	0,3	0,3	0,3	0,1	0,4
Measles	1,3	0,9	1,3	1,2	1,2	0,2	1,3	1,6	0,7	1,0
Diphtheria			0,1				0,2	0,6		
Syphilis	0,4	0,5	0,4	0,3	0,2		0,4	0,1	0,2	0,1
Bronchitis and pneumonia	12,5	9,3	9,3	8,5	7,3	7,9	9,1	8,7	7,5	8,9
Gastro enteritis	20,4	14,1	16,2	19,9	13,9	10,0	11,7	11,3	9,8	11,5
Prematurity	11,3	8,7	6,8	6,4	9,2	6,1	8,2	8,0	8,1	8,2
Injury at birth	3,3	2,8	3,0	2,9	1,2	0,9	1,0	0,8	0,3	0,1
Congenital malformations	4,8	3,6	3,5	3,6	2,0	2,1	2,1	2,6	1,6	1,7
Other diseases of early infancy	13,3	10,0	11,7	9,9	6,9	6,3	0,3	3,3	3,4	2,9
Other cases	11,1	7,3	4,2	5,8	3,3	3,7	11,1	8,9	6,7	8,0
ALL CAUSES	79	58	58	59	46	38	46	46	38	43

* Rates based on notified births.

Table III.XLIV Continued *INFANTS FROM 1 TO 2 YEARS OF AGE**

Period	Common infectious diseases		Tuberculous diseases		Syphillis		Bronchitis and pneumonia		Diarrhoea and enteritis		Developmental diseases		Miscellaneous diseases (remainder)		Total mortality (all causes)	
	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B
Quinquennium 1951 — 1952 to 1956	0,4	1,1	0,5	6,1		0,1	0,4	4,6	0,6	17,3	0,2	0,2	1,1	4,3	3,1	33,8
1957 — 1961	0,1	1,3		1,8		0,0	0,5	4,3	0,2	9,4	0,2	0,6	1,3	5,0	2,3	22,5
1962 — 1966	0,3	2,1		0,6			0,5	2,9	0,1	4,9	0,4	0,3	0,8	7,1	2,1	18,0
1967 — 1971	0,1	1,3		0,4			0,1	2,7		3,3	0,3	0,4	0,4	4,3	1,1	12,2
1971 — 1975		1,2		0,3			0,3	1,5		2,2	0,2	0,1	0,6	2,5	1,1	7,8
1972 — 1976		1,1		0,2			0,4	1,7		1,9	0,1	0,2	0,8	2,4	1,2	7,5
Year																
1967	0,3	1,3		0,5				3,7		3,6		0,8	0,8	6,4	1,1	16,3
1968 ¢		1,4		0,4			0,3	2,3		3,2		0,4	0,3	4,7	0,5	12,4
1969		1,4		0,2				2,9		3,0	0,5	0,3	0,8	4,3	1,3	12,1
1970		0,9		0,3			0,3	2,8		3,4	0,5	0,4	1,3	3,7	2,1	11,4
1971		1,4		0,4			0,2	1,7		3,1	0,5	0,3		2,2	0,7	9,0
1972		0,8		0,3			0,5	0,9		1,1	0,5	0,1	0,5	2,3	1,2	5,6
1973		1,2		0,2			0,7	2,0		3,1		0,1	0,5	2,6	1,2	9,2
1974		2,0		0,3				2,2		2,4		0,2	0,5	3,3	0,5	10,3
1975		0,6		0,2			0,3	0,9		1,1			1,5	1,9	1,8	4,8
1976		0,9		0,1			0,6	2,6		1,9		0,4	0,9	1,9	1,5	7,8

C = Coloured; A = Asiatic; B = Blacks

¢ Rates based on notified births from 1968.

* The rate for the year is calculated on the births (less the deaths under one year) in the previous year.

Table III.XLIV

INFANT MORTALITY RATES BY SELECTED CAUSES IN QUINQUENNIA 1951 – 1975 AND ANNUALLY 1967 – 1976

Period	Common infectious diseases		Tuberculous diseases		Syphilis		Bronchitis and pneumonia		Diarrhoea and enteritis		Developmental diseases		Miscellaneous diseases (remainder)		Total mortality (all causes)	
	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B
Quinquennium 1951 – 1952 to 1956	0,1	1,0	0,2	4,2		0,5	2,3	15,1	2,3	42,9	15,0	25,8	5,1	14,2	25,6	103,6
1957 – 1961		1,4		1,3		0,2	2,4	13,2	1,0	31,6	13,5	23,4	5,0	14,9	21,8	85,9
1962 – 1966	0,2	2,2		0,4		0,2	1,6	11,8	1,3	21,9	13,0	27,1	3,9	14,4	20,0	78,0
1967 – 1971	0,1	1,5		0,5	0,1	0,3	1,4	9,4	0,8	16,8	10,2	22,4	2,7	8,9	15,3	59.8
1971 – 1975		1,2		0,3		0,2	1,1	8,1	0,2	11,3	8,9	15,0	2,2	6,7	12,5	42,7
1972 – 1976	0,1	1,2		0,3		0,2	1,0	8,4	0,1	10,9	8,4	13,9	2,4	7,4	12,1	42,2
Year																
1967	0,3	2,2		0,9		0,4	1,1	12,5	0,8	20,1	10,3	29,7	2,1	13,0	14,8	78,9
1968*		1,4		0,3		0,5	1,3	9,3	0,5	14,1	10,4	22,2	2,6	9,7	14,9	57,6
1969		1,3		0,6	0,3	0,3	1,5	9,3	0,8	16,2	12,7	21,9	2,8	8,3	18,0	58,0
1970		1,3		0,2		0,3	1,2	8,5	1,2	19,9	9,1	20,0	4,3	8,7	15,8	58,8
1971		1,2		0,3		0,2	1,9	7,3	0,7	13,9	8,6	18,2	1,6	4,6	12,8	45,6
1972		0,8		0,3			0,7	7,9		10,0	9,5	14,5	2,4	4,7	13,0	38,1
1973		1,6		0,3		0,4		9,1	0,3	11,7	9,3	15,4	3,2	7,3	12,7	45,8
1974		1,8		0,3		0,1	0,8	8,7		11,3	8,6	13,9	2,5	9,7	12,0	45,8
1975		0,7		0,1		0,2	2,1	7,5		9,8	8,5	12,9	1,5	7,2	12,2	38,3
1976	0,3	1,0		0,4		0,1	1,3	8,9	0,3	11,5	6,0	12,8	2,5	8,1	10,4	43,0

C – Coloured; A = Asiatic; B – Blacks

* Rates based on notified births from 1968.

Table III.XLV *CORRECTED DEATHS OF INFANTS UNDER THE AGE OF ONE YEAR BY MONTH OF REGISTRATION : 1971 – 1976*

	1971	1972	1973	1974	1975	Mean Previous 5 years	1976
January	87	61	75	54	68	69	48
February	108	—	53	60	72	59	75
March	75	—	84	81	58	60	68
April	89	—	56	71	69	57	72
May	66	—	90	106	53	63	63
June	79	—	86	76	52	59	90
July	66	64	83	77	53	69	69
August	67	71	81	81	61	72	62
September	57	52	81	84	46	64	53
October	54	50	62	53	38	51	37
November	70	84	69	60	61	69	45
December	46	50	65	66	46	55	58
TOTAL	864	432	885	869	677	745	740
Mean	72,0	61,7	73,8	72,4	56,4	67,3	61,7
Per 1 000 live Notified births	39,2	33,5	40,2	40,2	34,0	37,4	37,7

Table III.XLVI — DEATHS OF INFANTS UNDER ONE YEAR OF AGE BY SELECTED CAUSES AND MONTH OF REGISTRATION : 1976

International Code No.	DISEASE	RACE	January	February	March	First Quarter	April	May	June	Second Quarter	July	August	September	Third Quarter	October	November	December	Fourth Quarter	YEAR	Percentage Total death	Rate per 1 000 live notified births
004,8,9	Diarrhoea and enteritis	White							1	1									1	3,0	0,3
561		C, A & B	10	33	28	71	34	22	16	72	12	4	6	22	6	8	11	25	190	26,8	11,5
010—012	Tuberculosis, Pulmonary and	White																			
014—019	other forms	C, A & B		1		1					1			1	2	1		3	5	0,7	0,3
013	Tuberculosis, meningeal	White																			
		C, A & B	1			1									1			1	2	0,3	0,1
032	Diphtheria	White																			
		C, A & B																			
033	Whooping cough	White																			
		C, A & B																			
038	Septicaemia	White			2	3		2		2		2	2	4		1	2	3	12	1,7	0,7
		C, A & B	1		1	1													1	3,0	0,3
055/6	Measles and rubella	White																			
		C, A & B	1			1	2	4	2	8	4	2	2	8					17	2,4	1,0
090	Syphilis, congenital	White																			
		C, A & B		1		1		1		1									2	0,3	0,1
259—266	Avitaminoses	White																			
		C, A & B		1		1													1	0,1	0,1
267—273	Nutritional Maladjustment	White							1	1									1	3,0	0,3
		C, A & B			1	1					1	2		3		1	1	2	6	0,8	0,4
320	Simple meningitis	White																			
		C, A & B	2		1	3	3		1	4	1		4	5	1			1	13	1,8	0,8
466	Bronchitis	White																			
490—1		C, A & B		1		1					1	1	4	6		1		1	8	1,1	0,5
480—6	Pneumonia (all forms)	White							2	2		2		2					4	12,1	1,3
		C, A & B	13	7	3	23	7	18	25	50	17	17	10	44	4	8	10	22	139	19,7	8,4
500—519	Postnatal Asphyxia and Atelectasis	White																			
		C, A & B		1	1	2			1	1		1		1	1			1	5	0,7	0,3
740 —	Congenital Anomalies	White	1			1	1	1	2	4		1		1			1	1	7	21,2	2,2
759		C, A & B	2	4	4	10	1	1	2	4	1	3	3	7	3	3	1	7	28	4,0	1,7
772	Injury at birth	White																			
		C, A & B														1	1	2	2	0,3	0,1
774/5	Haemolytic Diseases of new born	White						1		1									1	3,0	0,3
		C, A & B																			
776,8	Other Diseases Peculiar to early Infancy	White																			
		C, A & B	2	6	1	9	3	4	2	9		4	1	5	5	4	4	13	36	5,1	2,2
777	Prematurity	White	1	2		3	1		1	2		1		1	1	1	2	4	10	30,3	3,1
		C, A & B	9	9	16	34	5	6	16	27	19	12	14	45	8	7	14	29	135	19,1	8,2
E913	Accidental mechanical suffocation	White											1	1					1	0,1	0,1
		C, A & B																			
	Other and ill-defined or unknown causes	White		1	2	3	1	1		2		1	2	3					8	24,2	2,5
		C, A & B	5	8	8	21	14	2	18	34	12	9	4	25	5	9	11	25	105	14,9	6,4
	TOTALS	White	2	3	3	8	3	3	7	13		5	2	7	1	1	3	5	33	100	10,4
		C, A & B	46	72	65	183	69	60	83	212	69	57	51	177	36	44	55	135	707	100	43,0

Table III.XLVII

INFANT DEATHS UNDER THE AGE OF ONE YEAR BY RACE, SEX, PLACE OF DEATH, LEGITIMACY AND WHETHER NEO-NATAL OR POST NEONATAL : 1976

	Place of Death	ALL INFANTS						LEGITIMATE						ILLEGITIMATE						UNKNOWN					
		Neo-natal			Post neo-natal			Neo-natal			Post neo-natal			Neo-natal			Post neo-natal			Neo-natal			Post neo-natal		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
White	Hospital	14	6	20	3	7	10	9	5	14	3	6	9							5	1	6		1	1
	Domiciliary				3		3				2		2										1		1
Coloured	Hospital	83	60	143	49	56	105	25	26	51	15	22	37	34	21	55	26	25	51	24	13	37	8	9	17
	Domiciliary	20	9	29	50	58	108	8	2	10	17	22	39	8	3	11	28	27	55	4	4	8	5	9	14
Asiatic	Hospital																								
	Domiciliary	1		1				1		1															
Blacks	Hospital	30	46	76	52	60	112	2	9	11	4	6	10	11	11	22	17	26	43	17	26	43	31	28	59
	Domiciliary	8	10	18	64	51	115	1	1	2	5	11	16	2	1	3	18	15	33	5	8	13	41	25	66
Total	Hospital	127	112	239	104	123	227	36	40	76	22	34	56	45	32	77	43	51	94	46	40	86	39	38	77
	Domiciliary	29	19	48	117	109	226	10	3	13	24	33	57	10	4	14	46	42	88	9	12	21	47	34	81
	TOTAL	156	131	287	221	232	453	46	43	89	47	67	113	55	36	91	89	93	182	55	52	107	86	72	158

Table III.XLVII

Table III.XLVIII *INFANT MORTALITY RATES BY RACE AND LEGITIMACY (EXCLUDING 265 DEATHS WHERE LEGITIMACY NOT KNOWN) : 1975 – 1976*

RACE	RATE PER 1 000 LIVE BIRTHS, BASED ON NOTIFICATIONS			
	LEGITIMATE		ILLEGITIMATE	
	1975	1976	1975	1976
White	11,4	8,8	19,0	
Coloured	21,4	18,8	38,8	36,0
Asiatic	4,3	3,9		
Blacks	14,5	22,7	40,2	42,2
T O T A L	17,8	16,6	38,5	36,4

Table III.XLIX *DEATHS AND DEATH RATES BY RACE DURING THE PERI-NATAL, NEO-NATAL AND, POST-NEONATAL PERIODS OF LIFE : 1975 – 1976*

	PERI NATAL PERIOD			
	Still births & Deaths under 1 week		Rate per 1 000 deliveries based on births and still births	
	1975	1976	1975	1976
White	43	41	13	13
Coloured	347	338	28	28
Asiatic	4	3	16	11
Blacks	164	161	40	38
ALL RACES	558	543	28	27
	NEO NATAL PERIOD			
	Deaths		Rate per 1 000 live births	
White	27	20	8	6
Coloured	183	172	15	14
Asiatic	1	1	4	4
Blacks	81	94	20	23
ALL RACES	292	287	15	15
	POST NEO NATAL PERIOD			
	Deaths		Rate per 1 000 live births	
White	13	13	4	4
Coloured	213	209	17	17
Asiatic	1		4	
Blacks	158	231	39	56
ALL RACES	385	453	19	23

Table III.L

PERI-NATAL, NEO-NATAL AND POST NEO-NATAL MORTALITY RATES : 1972 – 1976

YEAR	WHITE			COLOURED, ASIATIC AND BLACKS		
	Peri-natal	Neo-natal	Post neo-natal	Peri-natal	Neo-natal	Post neo-natal
1972	16	10	3	32	16	22
1973	16	10	3	34	19	27
1974	15	8	4	35	18	28
1975	13	8	4	30	16	22
1976	13	6	4	30	16	27
Average 1972 — 1976	15	8	4	32	17	25

Table III.LI

MATERNAL MORTALITY : DEATHS FROM CAUSES ASCRIBED TO PREGNANCY AND CHILDBIRTH (INCLUDING ABORTION) AND THE CORRESPONDING DEATH RATE PER 1 000 LIVE AND STILL BIRTHS : 1976

Int. Code No.	CAUSE OF DEATH	DEATHS					Maternal mortality rates
		White	Coloured	Asiatic	Blacks	Total	Total
630—634	Complications of pregnancy						
635—639	Infections & Toxaemias of Pregnancy and the Puerperium						
640—645	Abortion		5		3	8	0,40
650—662	Delivery				1	1	0,05
670—678	Complications of the Puerperium						
			5		4	9	0,45

Table III.LII

MATERNAL MORTALITY RATES (DEATHS PER 1 000 LIVE AND STILL BIRTHS) : 1972 – 1976

	Puerperal septicaemia			Other causes			All causes		
	White	C, A & B	Total	White	C, A & B	Total	White	C, A & B	Total
1972	—	0,11	0,09	—	0,16	0,13	—	0,27	0,22
1973	—	0,11	0,09	—	0,05	0,04	—	0,16	0,13
1974	—	0,05	0,05	—	0,22	0,18	—	0,27	0,23
1975	—	—	—	—	0,30	0,25	—	0,30	0,25
1976	—	—	—	—	0,54	0,45	—	0,54	0,45

Table III.LIII *VITAL STATISTICS COMPARED WITH OTHER CENTRES*

(Latest Available Figures)

CENTRE	YEAR	Birth Rate					Death Rate					Infant Mortality Rate					All forms of Tuberculosis Death Rate				
		W	C	A	B	C, A & B	W	C	A	B	C, A & B	W	C	A	B	C, A & B	W	C	A	B	C, A & B
Cape Town	1976	12,6	25,3	23,9	40,9	27,9	8,8	6,8	4,5	12,4	7,7	10	32	4	79	43	0,02	0,16		0,87	0,28
King William's Town	1976	13,2	29,6	11,9	10,8		5,6	8,8		7,5			94		133			0,93		0,48	
Port Elizabeth	1975	18,5	31,1	21,5	25,5		8,3	15,0	7,7	13,7		18	105	84	130						
Springs	1976	16,3	21,4	17,4	29,8		5,2	7,3	1,5	8,7		14	77	87	76						
Benoni	1975	19,3		33,0	26,7		5,5		12,3	10,9		16		52	119					0,36	
Durban	1974	14,3	33,9	29,5	42,5		9,7	6,3	7,4	10,3		15	24	29	73		0,01	0,12	0,02	0,18	
Bloemfontein	1975	18,9	26,3		18,7		6,9	13,1		10,6		19	109		126						
Vereeniging	1975	18,6	23,7	8,0	18,1		2,6	2,7	0,4	4,8		17			64		0,00	0,54	0,00	0,16	
Pretoria	1975	19,9	28,2	22,9	17,4	18,3	6,2	7,9	3,8	7,5	7,3	17			97	86	0,03	0,93	0,12	0,65	0,63
Johannesburg	1973	20,6	31,4	32,3	36,6		9,2	11,1	6,3	11,1		18	61	33	54						
East London	1971	25,8	40,2		85,9		12,4	12,9		16,5		17	63		76		0,15	1,30	0,49	1,84	
South Africa	Birth 1972. Death 1974	20,2	30,4	29,5	37,7		8,4	12,8	6,8	8,3		18	115	32							
England and Wales	1976	12,0					12,2					14									
Country of London	1972	14,1					11,8					17									

Table IV.I *FAMILY PLANNING CLINIC ATTENDANCES : 1971 – 1976*

Year	Individuals attending the clinics	Persons attending for the first time	Total attendances all clinics during the year	Race
1971	20 000(est.)	10 806	83 349	All
1972	26 841	12 069	89 809	All
1973	32 240	14 703	87 445	All
1974	42 094	18 701	97 189	All
1975	38 130	9 660	119 136	All
1976	2 572	316	6 812	White
	32 993	5 567	108 242	Coloured Asiatic
	5 190	1 922	12 663	Black
	40 755	7 805	127 717	All

Table IV.II *THE NUMBER OF INDIVIDUALS ATTENDING AT VARIOUS DIFFERENT FAMILY PLANNING CLINICS : 1972 – 1976*

CLINIC	1972	1973	1974	1975	1976
Shortmarket Street	768	744	877	829	753
Aspeling Street	1 382	1 529	1 827	1 332	1 192
Salt River	1 892	2 091	2 307	2 137	2 053
Maitland	520	595	670	477	500
Kensington	1 442	1 729	1 888	1 409	1 341
Langa	538	711	745	570	
Bokmakierie	1 720	2 024	2 646		
Silvertown	1 822	1 995	2 351	4 301	3 581
Bonteheuwel	2 057	2 400	2 782	2 123	2 099
Heideveld	1 162	1 488	2 425	1 925	2 325
Manenberg	1 867	2 123	2 699	2 355	2 120
Hanover Park	1 193	1 568	2 156	1 807	1 948
Netreg					493
Guguletu 1	2 934	3 046	3 889	3 321	2 881
Claremont (Station Road)	737	932	1 088	1 034	1 394
Lansdowne	1 438	1 585	2 052	1 656	1 742
Wynberg	2 215	2 467	3 163	3 096	3 233
Parkwood	648	735	954	807	782
Retreat	2 506	2 937	3 412	2 762	2 246
Lavender Hill				1 224	1 160
Muizenberg					48
Southfield					37
Factories (Misc.)		1 541	4 163	4 965	8 827
TOTALS	26 841	32 240	42 094	38 130	40 755

Table IV.III *ANALYSIS OF MODE OF CONTRACEPTION INITIALLY ADOPTED BY MEMBERS OF DIFFERENT RACE GROUPS : 1972 – 1976 (Figures reflect the percentage of New Acceptors in that group for each year)*

Race and Year		Oral Contraception	Intra-muscular Contraception	Intra-uterine Contraceptive Devices	Other
Whites	1972	76	13	7	4
	1973	76	15	7	2
	1974	77	17	5	2
	1975	81	16	1	1
	1976	74	14	10	2
Coloured and Asiatic	1972	66	28	3	3
	1973	59	34	4	3
	1974	52	43	2	3
	1975	46	51	1	2
	1976	52	43	3	2
Black	1972	45	50	4	1
	1973	44	52	4	0
	1974	37	61	2	0
	1975	33	65	2	0
	1976	43	55	1	1

Table IV.IV *THE PERCENTAGE OF WHITE AND COLOURED FEMALES IN THE CHILD BEARING AGE GROUP OF 15 – 49 YEARS REPRESENTED BY THE INDIVIDUAL ATTENDANCES RECORDED AT FAMILY PLANNING CLINICS : 1976*

	WHITE	COLOURED
Est. Total female population of Cape Town 1976	132 870	253 060
Est. Percentage of all females aged 15 — 49 years*	48,53%	48,68%
Number of females aged 15 — 49 years	64 481	123 190
Individuals attending clinics in 1976	2 572	32 993
Percentage of 15 — 49 year olds on Family Planning	4%	27%

* Calculated from Figure 3.2

Table IV.V *TOTAL ATTENDANCES AT ANTE-NATAL CLINICS: 1967 – 1976*

CENTRE	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Shortmarket Street	515	479	347							
Aspeling Street	1 382	1 429	1 334	1 762	1 732	1 617	1 490	1 504	1201	1 157
Woodstock	484	407	475	479						
Salt River					408	452	488	583	419	308
Maitland	453	363	345	141	140	334	283	202	149	26
Kensington	2 565	2 161	2 088	1 737	1 537	1 608	1 014	711	779	660
Langa	1 869	1 758	1 570	1 875	1 859	1 949	2 178	2 782	2 758	2 073
Athlone	3 699	3 328	3 339	3 196	2 898	2 540	2 207	2 430	1 350	
Bokmakierie	2 548	2 262	2 299	1 288	1 543	1 537	1 747	1 621	624	
Silvertown	2 122	1 922	2 303	2 156	2 659	3 253	3 169	2 333	1 665	2 630
Bonteheuwel	5 751	5 525	4 776	4 933	5 258	4 891	4 143	3 956	2 513	2 209
Heideveld	4 353	4 142	2 671	1 492	1 974	1 925	1 448	1 589	1 237	1 022
Manenberg		700	2 913	2 601	2 399	1 801	1 671	1 460	1 588	2 096
Hanover Park				169	2 085	3 709	5 461	2 621	1 929	1 391
Guguletu I	7 350	6 596	5 207	4 939	4 949	6 266	6 673	6 362	5 876	3 606
Guguletu III		1 343	2 388	2 465	3 062	3 179	2 935	2 895	2 906	1 526
Claremont	1 575	1 690	1 853	1 724	1 685	1 601	1 094			
Lansdowne	1 777	1 891	2 195	2 267	2 198	2 305	2 270	1 763	1 505	1 098
Wynberg	1 944	1 623	1 448	1 092	1 247	1 699	1 114	1 843	1 168	1 314
Parkwood				778	1 795	1 759	1 846	1 638	834	497
Elfindale							3			
Lavender Hill								2 388	2 057	1 628
Retreat	5 292	4 423	5 794	6 349	5 362	5 483	6 029	5 386	3 263	2 747
Kalk Bay	55	102	100	94	66	75	66	80	6	
TOTALS	43 734	42 144	43 445	41 537	44 856	47 983	47 329	44 147	33 827	25 988

Table IV.VI *NUMBER OF SESSIONS, FIRST AND TOTAL ATTENDANCES AT INFANT WELFARE, ANTE-NATAL AND SCHOOL EYE CLINICS : 1976*

CENTRE	Race	Infant Consultations				Pre Natal Clinics			School Eye Clinics		
		Sessions	1st Attendances		Total Attendances	Sessions	Attendances		Sessions	Attendances	
			Under 1 Year	Over 1 Year			1st	Total		1st	Total
Camps Bay	White	24	47		322						
Sea Point	White	52	270		2 436						
Kloof Street	White	52	215		2 112						
Shortmarket St	Coloured	85	307	3	3 269						
Aspeling Street	Coloured	101	494	2	6 350	47	575	1 157			
Bloemhof	Coloured	52	129		2 076						
Devil's Peak	White	22	69	2	525						
Salt River	White		116		1 378		13	25	2	14	43
	Other		388		5 351		190	283	162	837	3 340
	All Races	149	504		6 729	33	203	308	164	851	3 383
Brooklyn	White	52	167	9	1 978						
Maitland	White		85		566						
	Other		124	2	1 594		23	26			
	All Races	88	209	2	2 160	17	23	26			
Kensington	Coloured	162	642	1	11 858	30	396	660			
Factreton	Coloured	46	312	1	5 645						
Thornton	White	25	55		473						
Langa	Black	69	968	136	4 272	48	1 238	2 073			
Guguletu Sec.I	Black	156	1 757	110	11 445	99	1 213	3 606			
Guguletu Sec.III	Black	59	531	40	3 950	31	400	1 526			
Silvertown	Coloured	341	1 665		32 817	63	1 375	2 630	104	547	2 229
Bonteheuwel	Coloured	207	960	9	26 735	49	1 169	2 209			
Netreg	Coloured	151	353	6	13 102						
Heideveld	Coloured	246	778		17 860	51	727	1 022			
Manenberg	Coloured	248	1 039	2	28 873	86	992	2 096			
Newfields	Coloured	45	67	6	1 303						
Hanover Park	Coloured	248	910	9	21 637	78	963	1 391			
Claremont (Station Road)	White	103	636	3	5 326						
Claremont (Wesley Street)	Coloured	38	86		1 290						
Lansdowne	White		110	1	1 389						
	Other		561	3	10 082		325	1 098			
	All Races	196	671	4	11 471	48	325	1 098			
Wynberg	White		114	1	674						
	Other		323		3 950		371	1 314			
	All Races	75	437	1	4 624	51	371	1 314			
Ottery	White	22	64	1	584						
Southfield	White	50	291		2 909						
Parkwood	Coloured	96	404	1	9 135	46	251	497			
Bergvliet	White	35	150		1 038						
Elfindale	Coloured	47	149		1 903						
Lavender Hill	Coloured	173	805	11	20 231	48	656	1 628			
Retreat	Coloured	250	1 162	44	25 250	51	1 056	2 747			
Muizenberg	White	29	98	7	748						
Kalk Bay	White										
	Other		19		356						
	All Races	23	19		356						
TOTALS	White		2 487	24	22 458		13	25		14	43
	Other		14 933	386	270 334		11 920	25 963		1 384	5 569
	All Races	3 817	17 420	410	292 792	876	11 933	25 988	268	1 398	5 612

Table IV.VII *TOTAL ATTENDANCES AT INFANT WELFARE CLINICS; 1967 – 1976*

CENTRE	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Camps Bay	773	784	939	657	597	676	660	459	324	322
Sea Point				454	1 278	1 250	1 486	1 547	1 927	2 436
Green Point	1 980	1 504	1 449	1 427	1 403	1 174				
Kloof Street	2 379	2 804	2 417	2 661	2 656	2 672	2 093	1 863	1 819	2 112
Shortmarket St	8 764	7 023	5 727	4 753	4 500	4 589	4 084	3 451	3 483	3 269
Aspeling Street	14 430	13 999	13 362	13 265	12 649	12 804	11 656	8 979	7 390	6 350
Bloemhof	8 074	8 973	8 105	7 606	6 346	4 924	3 303	2 631	2 237	2 076
Devil's Peak	1 650	1 866	1 674	1 229	1 524	1 455	962	463	409	525
Woodstock	12 168	11 093								
Salt River			12 639	9 858	8 949	10 137	9 819	8 559	7 118	6 729
Brooklyn	2 996	3 159	2 770	2 317	1 857	1 962	1 748	1 940	1 684	1 978
Maitland	3 994	3 446	3 786	3 190	2 784	3 257	3 135	2 959	2 423	2 160
Kensington	19 236	20 303	19 101	16 196	17 927	16 030	13 485	11 690	11 846	11 858
Factreton	8 885	8 676	9 224	8 413	8 145	6 974	6 238	5 308	5 902	5 645
Thornton					510	594	543	612	448	473
Langa	3 602	2 812	2 946	2 800	2 944	3 387	3 392	3 694	4 058	4 272
Athlone	22 857	17 305	15 388	14 603	15 150	16 194	14 846	15 054	13 329	
Bokmakierie	12 858	11 442	12 903	8 963	10 332	11 234	9 640	8 756	6 872	
Silvertown	18 162	18 142	17 504	16 087	15 519	16 893	15 973	13 454	15 676	32 817
Bonteheuwel	40 396	37 262	33 042	28 984	28 467	27 586	25 855	23 971	26 856	26 735
Netreg		7 102	19 477	15 083	16 776	12 606	14 578	16 843	14 260	13 102
Heideveld	20 131	24 845	25 164	22 628	20 954	19 477	19 117	23 689	23 377	17 860
Kalksteenfontein	8 119	5 441								
Sherwood Park	4 944	3 582								
Manenberg		6 660	34 357	45 480	56 694	47 544	48 853	40 557	29 343	28 873
Hanover Park				856	25 201	43 453	47 125	35 960	24 399	21 637
Newfields							186	809	549	1 303
Guguletu I	17 503	13 663	9 543	8 758	10 387	12 218	14 592	15 070	13 383	11 445
Guguletu II		3 813	7 173	7 463	7 941	8 006	6 696	6 100	6 353	3 950
Claremont (Station Road)	8 481	8 417	8 469	7 685	5 827	5 358	4 383	3 886	3 636	5 326
Claremont (Wesley Street)	6 211	6 936	5 583	5 372	4 728	4 022	3 267	2 971	2 296	1 290
Lansdowne	15 005	14 241	13 167	13 963	12 272	13 750	13 611	12 053	10 537	11 471
Bergvliet							350	588	703	1 038
Wynberg	9 611	7 275	6 814	6 076	6 600	6 401	6 364	5 603	4 307	4 624
Ottery					461	323	179	416	566	584
Southfield	3 816	3 133	450	676	867	1 043	1 182	2 215	2 510	2 909
Parkwood		1 695	4 242	9 039	12 719	12 081	12 252	12 252	11 247	9 135
Elfindale							1 249	2 067	2 049	1 903
Heathfield	9 031	7 211	6 348	5 566	4 570	4 129	2 002			
Retreat	34 117	40 035	39 695	29 068	23 412	25 066	35 436	31 617	22 845	25 250
Lavender Hill							3 088	17 838	20 264	20 231
Muizenberg (John Power)	5 253	5 850	5 763	5 346	3 796	3 458	5 454			
Muizenberg							40	261	345	748
Kalk Bay	666	844	784	690	597	420	353	337	444	356
	326 092	331 336	350 005	327 212	357 339	363 147	369 275	346 522	307 214	292 792

Table IV.VIII AGE AT WHICH IMMUNISATIONS ARE ROUTINELY ADMINISTERED

AGE	IMMUNISATION	AGE	IMMUNISATION
3 months	BCG Polio Diphtheria Whooping cough Tetanus	(8 months)	(Heaf)
		9 months	Measles
		12 months	Smalpox
$4^{1}/2$ months	Polio Diphtheria Whooping cough Tetanus	18 months	Diphtheria Whooping cough Tetanus
6 months	Polio Diphtheria Whooping cough Tetanus	5 years	Diphtheria Tetanus
		Adults	Polio

Table IV.IX IMMUNISATIONS AGAINST POLIOMYELITIS; DIPHTHERIA (D); WHOOPING COUGH (PERTUSSIS) (W OR P); AND TETANUS (T) : 1976

a) POLIOMYELITIS

	Less than 1 year		1 — 4 years		Other ages		Total	
	White	C, A & B	White	C, A & B	White	C, A & B	White	C, A & B
First dose	3 131	15 961	130	1 212	211	132	3 472	17 305
Second dose	2 983	14 163	84	1 289	98	52	3 165	15 504
Completed course (three doses)	2 786	12 366	127	1 320	67	41	2 980	13 727
Booster after 3 doses	206	137	6	95	1 837	7 841	2 049	8 073

b) DIPHTHERIA, WHOOPING COUGH AND TETANUS

AGE GROUP

	Less than 1 year			1 — 6 years				School Age				
	1st	2nd	3rd	1st	2nd	3rd	Booster	1st	2nd	3rd	Booster	TOTAL
White	3 004	2 823	2 630	157	137	224	1 969	1	3	2	2 450	13 400
C, A & B	15 962	14 018	12 149	1 389	1 580	1 640	10 789	86	48	16	17 699	75 376
TOTAL	18 966	16 841	14 779	1 546	1 717	1 864	12 758	87	51	18	20 149	88 776

c) MATERIAL USED

RACE	Diph.	D/WC/T.	D/TET.	Adorbed Dissolved Floccules	TET.
White	2	9 997	3 398		3
C, A & B	1	49 980	25 322	1	72
TOTAL	3	59 977	28 720	1	75

C = Coloured; A = Asiatic; B = Blacks

Table IV.X *ATTENDANCES AT THE CAPE TOWN CITY COUNCIL CRECHES AND NURSERY SCHOOLS : 1976*

Nursery School	Creche attached	Sessions	New entrants	Ave. total on register	Ave. Attendances per session	Total Attendances
Bloemhof		201	21	42	37	7 459
Shelley Street		211	32	50	38	8 006
Liberman		211	6	36	15	3 253
Langa	Yes	232	66	80	65	15 199
Bokmakierie	Yes	211	78	80	96	20 346
Bonteheuwel	Yes	200	12	80	67	13 396
Heideveld	Yes	200	17	80	71	14 168
Manenberg	Yes	110	31	80	71	7 830
Guguletu NY 6	Yes	232	5	80	68	15 834
Guguletu NY 50	Yes	146	17	80	69	10 052
Retreat	Yes	200	27	80	70	14 050

Note:: All those nursery schools registered for 80 children, cater for 60 children aged 2 – 6 years and 20 children from 3 months to 2 years. Guguletu NY50 was destroyed by fire during the year and Manenberg was severely damaged by arsonists.

Table IV.XI *OPHTHALMIC SCHOOL CLINICS HELD, ATTENDANCES THEREAT AND THE NUMBER OF SPECTACLES FITTED : 1976*

	White	Coloured, Asiatic and Black	Total
Number of new cases	14	1 384	1 398
Total attendances	43	5 569	5 612
Number of sessions held			268
Children fitted with spectacles	51	1 690	1 741
Part paying	31	1 487	1 518
Free	20	203	223

Table IV.XII *ATTENDANCES AT GERIATRIC CLINICS : 1976*

CLINIC: AS FROM:	HEIDEVELD 1976—01—01	SILVERTOWN 1976—08—01	RETREAT 1976—11—05
Number of Sessions held	51	16	7
Number of New attendances	220	122	57
Number of Total attendances	275	122	57
Denture referrals	180	45	24
Dentures supplied	1		
Spectacle referrals	190	70	25
Spectacles supplied	1		
Hearing aid referrals	22	11	7
Hearing aid supplied	1		
Chiropody referrals	46	40	17
Social Worker referrals	25	13	8
Physiotherapy referrals	3	7	
Day Hospital referrals	179	28	41

Table IV.XIII

HEALTH EDUCATION LECTURES GIVEN DURING 1976 BY VENUE, SUBJECT, AUDIENCE, MEDIA UTILISED, NUMBER OF LECTURES AND ATTENDANCES

VENUES	SUBJECTS	AUDIENCE BY RACE	TYPE OF AUDIENCE	MEDIA UTILISED	NO. OF LECTURES	ATTENDANCES
Child Welfare Clinics and Community Centres	Nutrition, family planning, cervical cytology, tuberculosis, food- borne disease, infant care and feeding, immunisation, general and personal hygiene, accident prevention, care of feeding bottles and teats, physiology of labour.	White Coloured Blacks	Mothers Mothers Mothers	Films, film-strips, 35mm slides, flannelgraphs and flip-charts	31 1 025 841	950 65 550 25 230
Tuberculosis Clinics	Tuberculosis, nutrition, family planning	Coloured Blacks	TB Out-patients	Films, flannelgraphs	19 26	7 000 2 500
Hospitals	Nutrition, family planning, tuberculosis, mouth to mouth resuscitation	Coloured Blacks	Nursing staff patients in wards, out-patients	Films	49 21	4 300 3 440
Voluntary Organisations	Family planning, nutrition, venereal diseases, mouth to mouth resuscitation	Coloured Blacks	Adult male and females Adult male and females	Films, slides, flannelgraphs and flip-charts	28 8	4 560 2 100
Food Premises	Food hygiene, personal hygiene, hygiene, elementary bacteriology	White Coloured Blacks	Employees Engaged in food preparation and handling	Films, filmstrips, flannelgraphs	12 35 4	500 6 000 280
Technical Colleges	Principles and techniques of health education	White	(Public health Nurses and Health inspectors)	Films, flannelgraphs and slides	8	212
Nurses' Training College	Health education and public health	Coloured	Trainee nurses	Slides	5	350
Schools	Pollution, drugs, smoking and health, mouth to mouth resuscitation, dental hygiene and public health	White Coloured Blacks	Scholars at both primary and secondary level	Films, flannelgraphs, slides	15 22 8	3 900 5 850 550
Factories	Family planning, sex education, venereal diseases, tuberculosis, nutrition, mouth to mouth resuscitation	White Coloured Blacks	Employees: Male and female	Films, and flannelgraphs	18	4 500

Table IV.XIV *ANALYSIS OF HOME VISITING BY REASON FOR, OR NATURE OF, THE VISITS: 1975 – 1976*

	1975	1976	% CHANGE
Routine House to House	20 332	29 576	+ 45,5 %
Family Planning Defaulters	1 054	1 096	+ 4 %
Ante-Natal Cases	1 287	1 126	− 12,5 %
Midwives	1 105	463	− 58 %
New Births	50 689	17 427	**
Immunisation Defaulters	4 081	3 541	− 13 %
Protected Infants	1 120	1 232	+ 10 %
Infectious Diseases			
Tuberculosis — New Cases	3 304	3 079	− 7 %
Follow Up	38 792	26 561	− 32 %
Gastro-Enteritis	186	301	+ 62 %
Venereal Disease	480	977	+ 104 %
Other	254	204	− 20 %
Total	43 016	31 122	− 28 %
Geriatrics	3 048	8 944	+ 193 %
Other*	55 916	80 691	**
TOTAL	181 648	175 218	− 3,5 %

* Deaths, Still births, heaf test readings, sub-visits from three months to school age, hearing tests, school children, psychiatric patients, hospital follow-up visits.

** Change in data collection renders comparisons between years impossible, 1975 figure includes subsequent visits to new births under 'new births'.

Table V.I NOTIFICATIONS OF TUBERCULOSIS (ALL FORMS) BY THE FORM OF DISEASE AND RESIDENTIAL STATUS OF THE PATIENT : 1976

	PULMONARY					OTHER FORMS					ALL FORMS				
	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T
City	54	920	1	100	1 075	3	23			26	57	943	1	100	1 101
Langa		1		402	403				3	3		1		405	406
Guguletu		4		490	494				12	12		4		502	506
TOTAL LOCAL	54	925	1	992	1 972	3	23		15	41	57	948	1	1 007	2 013
Imported	8	96	1	509	614		3		5	8	8	99	1	514	622
Out of City	19	16		15	50		2		3	5	19	18		18	55
TOTAL	81	1 037	2	1 516	2 636	3	28		23	54	84	1 065	2	1 539	2 690

	PULMONARY																								
	LUNGS					PLEURAL EFFUSION					PRIMARY COMPLEX OR MEDIASTINAL GLANDS					TUBERCULIN POSITIVE UNDER 5 YEARS					TOTAL 'PULMONARY FORMS'				
	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T
City	47	651	1	98	797	1	40		1	42		175			175	6	54		1	61	54	920	1	100	1 075
Langa		1		350	351				14	14				31	31				7	7		1		402	403
Guguletu		4		334	338				16	16				109	109				31	31		4		490	494
TOTAL LOCAL	47	656	1	782	1 486	1	40		31	72		175		140	315	6	54		39	99	54	925	1	992	1 972
Imported	5	86	1	415	507	2	3		18	23		5		65	70	1	2		11	14	8	96	1	509	614
Out of City	19	15		15	49							1			1						19	16		15	50
TOTAL	71	757	2	1 212	2 042	3	43		49	95		181		205	386	7	56		50	113	81	1 037	2	1 516	2 636

	FORMS OF TUBERCULOSIS OTHER THAN PULMONARY																														
	MENINGES					ABDOMINAL					ORTHOPAEDIC					GLANDS OTHER THAN MEDIASTINAL					GENITO-URINARY SYSTEM					OTHER ORGANS					TOTAL 'OTHER FORMS'				
	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T
City		12			12		3			3	1	2			3		2			2	1	1			2	1	3			4	3	23			26
Langa				1	1				1	1									1	1													3	3
Guguletu				7	7				1	1				2	2				1	1									1	1				12	12
TOTAL LOCAL		12		8	20		3		2	5	1	2		2	5		2		2	4	1	1			2	1	3		1	5	3	23		15	41
Imported		2		2	4				1	1												1			1				2	2		3		5	8
Out of City		1		3	4							1			1																	2		3	5
TOTAL		15		13	28		3		3	6	1	3		2	6		2		2	4	1	2			3	1	3		3	7	3	28		23	54

W = White; C = Coloured; A = Asiatic; B = Blacks

Table V.II *PULMONARY TUBERCULOSIS (AFFECTING PLEURA, LUNGS, PULMONARY LYMPHATIC DRAINAGE SYSTEM AND INCLUDING TUBERCULIN POSITIVE CHILDREN UNDER THE AGE OF FIVE YEARS WHO HAVE NOT HAD BCG); NOTIFICATIONS AND INCIDENCE RATES PER 1 000 POPULATION FOR LOCAL CASES AND NOTIFICATIONS OF IMPORTED CASES, BY RACE : 1975 – 1976*

	LOCAL CASES ONLY				IMPORTED CASES	
	NOTIFICATIONS		RATE PER 1 000 POPULAITON		NOTIFICATIONS	
	1975	1976	1975	1976	1975	1976
White	48	54	0,19	0,21	7	8
Coloured	758	925	1,65	1,94	55	96
Asiatic	2	1	0,19	0,09	4	1
Black	878	992	9,04	9,87	390	509
TOTAL	1 686	1 972	2,06	2,34	456	614

Table V.III *NOTIFICATIONS OF AND DEATHS FROM FORMS OF TUBERCULOSIS OTHER THAN PULMONARY FOR LOCAL CASES; AND NOTIFICATIONS OF SUCH CASES OF IMPORTED INFECTION, BY RACE : 1976*

	LOCAL CASES					IMPORTED CASES					NOTIFIED DEATHS				
	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T
Meninges		12		8	20		2		2	4		5		6	11
Abdominal		3		2	5				1	1					
Orthopaedic	1	2		2	5										
Glands		2		2	4									1	1
Genito-urinary	1	1			2		1			1					
Other	1	3		1	5				2	2		1		5	6
TOTAL	3	23		15	41		3		5	8		6		12	18

W = White; C = Coloured; A = Asiatic; B = Blacks

Table V.IV *NOTIFICATION RATES OF PULMONARY AND OTHER FORMS OF TUBERCULOSIS SEPARATELY AND TOGETHER FOR LOCAL CASES, BY RACE : 1972 – 1976 (NB: DEFINITION OF PULMONARY FORMS CHANGED IN 1976 – SEE TEXT).*

	1972	1973	1974	1975	1976
PULMONARY					
White	0,22	0,21	0,17	0,19	0,21
Coloured	1,61	1,53	1,62	1,65	1,94
Asiatic	0,02	0,69	0,57	0,19	0,09
Black	7,47	7,93	8,13	9,04	9,87
TOTAL	1,86	1,85	1,93	2,06	2,34
OTHER					
White	0,03	0,01	0,02	0,03	0,01
Coloured	0,39	0,40	0,51	0,52	0,05
Asiatic	0,10	0,01		0,09	
Black	1,90	2,13	2,53	2,51	0,15
TOTAL	0,45	0,48	0,59	0,60	0,05
ALL FORMS					
White	0,25	0,22	0,19	0,22	0,22
Coloured	2,00	1,93	2,14	2,17	2,01
Asiatic	0,12	0,7	0,57	0,28	0,09
Black	9,37	10,06	10,66	11,55	10,02
TOTAL	2,31	2,33	2,52	2,66	2,39

Table V.V *NUMBERS OF DEATHS FROM, AND DEATH RATES PER 1 000 POPULATION DUE TO, PULMONARY TUBERCULOSIS : 1975 – 1976*

	DEATHS		RATE PER 1 000 POPULATION	
	1975	1976	1975	1976
White	1	4	0,00	0,02
Coloured	80	71	0,17	0,15
Asiatic	—	—	—	—
Black	76	75	0,78	0,75
TOTAL	157	150	0,19	0,18

Table V.VI *DEATH RATES PER 1 000 POPULATION FOR PULMONARY AND OTHER FORMS OF TUBERCULOSIS, BY RACE : 1972 – 1976*

RACE	PULMONARY TUBERCULOSIS					TUBERCULOSIS, OTHER FORMS				
	1972	1973	1974	1975	1976	1972	1973	1974	1975	1976
White	0,05	0,03	0,02	0,00	0,02	—	—	0,01	—	—
Coloured	0,26	0,31	0,18	0,17	0,15	0,02	0,04	0,02	0,01	0,01
Asiatic	0,30	0,20	—	—	—	—	—	—	—	—
Black	0,92	0,54	0,77	0,78	0,75	0,08	0,01	0,21	0,05	0,12
TOTAL	0,27	0,25	0,20	0,19	0,18	0,02	0,02	0,04	0,01	0,02

Table V.VII *DEATH RATES PER 1 000 POPULATION OF ALL FORMS OF TUBERCULOSIS BY QUINQUENNIA : 1951/1956 TO 1972/1975 AND ANNUALLY 1972 – 1976*

	DEATH RATE PER 1 000 POPULATION		
	WHITE	COLOURED, ASIATIC AND BLACKS	ALL RACES
5 Years Ended Dec., 1956	0,20	1,70	1,09
5 Years Ended Dec., 1961	0,16	0,71	0,50
5 Years Ended Dec., 1966	0,08	0,49	0,34
5 Years Ended Dec., 1971	0,04	0,43	0,30
5 Years Ended Dec., 1975	0,03	0,38	0,25
Calender Year 1972	0,05	0,41	0,29
Calender Year 1973	0,03	0,38	0,27
Calender Year 1974	0,03	0,33	0,24
Calender Year 1975	0,00	0,29	0,21
Calender Year 1976	0,02	0,28	0,20

Table V.VIII *CLASSIFICATION OF PERSONS ATTENDING CITY HEALTH DEPARTMENT CLINICS FOR THE FIRST TIME AS TO WHETHER THEY WERE NOTIFIED CASES, CONTACTS OR SUSPECTS; AND ANY CHANGE TO THIS DESCRIPTION : 1976*

Persons attending for first time	WHITE					COLOURED, ASIATIC AND BLACKS					
	Adults		Children		Total	Adults		Children		Total	All races
	M	F	M	F		M	F	M	F		
Notified:											
Accepted	5	3			8	86	53	29	20	188	196
Not accepted											
TOTAL	5	3			8	86	53	29	20	188	196
Contacts:											
Notified	3		1	1	5	24	45	126	117	312	317
Non-Tuberculous	66	123	65	57	311	705	135	1 101	1 178	3 119	3 430
TOTAL	69	123	66	58	316	729	180	1 227	1 295	3 431	3 747
Suspects:											
Notified	16	10	3	1	30	833	385	201	251	1 670	1 700
Non-Tuberculous	125	152	29	39	345	1 801	1 493	684	735	4 713	5 058
TOTAL	141	162	32	40	375	2 634	1 878	885	986	6 383	6 758
TOTAL	215	288	98	98	699	3 449	2 111	2 141	2 301	10 002	10 701

Table V.IX *MASS MINIATURE RADIOGRAPHY AT THE CHAPEL STREET CLINIC – NUMBERS OF EXAMINATIONS BY RACE AND SEX : 1974 – 1976*

Period	White		Coloured, Asiatic and Blacks		Total
	Males	Females	Males	Females	
1974	7 398	4 794	26 482	23 092	61 766
1975	9 025	4 954	32 891	21 719	68 589
1976	8 320	4 131	28 952	22 221	63 624

In addition to the 63 624 miniature film examinations made during the year, 750 100mm films were taken as compared with 853 in the previous year.

Table V.X *AGE – RACE – SEX CLASSIFICATION OF PERSONS SCREENED BY MASS MINIATURE RADIOGRAPHY AT THE CHAPEL STREET CLINIC : 1975 – 1976*

Year	Race	Active Tuberculosis Discovered										Extra municipal cases included in foregoing)	
		Age-Groups								Total			
		15—24		25—34		35—44		45 +					
		M	F	M	F	M	F	M	F	M	F	M	F
1975	White	1		3	2	1	—	2	1	7	3	—	2
	C, A & B	22	15	31	7	43	8	53	9	149	39	25	10
	TOTAL	23	15	34	9	44	8	55	10	156	42	25	12
1976	White	—	1	—	1	—	—	2		2	2	—	—
	C, A & B	23	16	31	15	39	8	31		124	39	26	11
	TOTAL	23	17	31	16	39	8	33		126	41	26	11

Table V.XI *RESULTS OF MASS MINIATURE RADIOGRAPHY AT THE CHAPEL STREET CLINIC : 1972 – 1976*

	1972	1973	1974	1975	1976
Persons screened	65 349	63 097	61 766	68 589	63 624
Recalled for further investigation	1 427	1 046	901	795	835
Recalls who failed to attend				255	295
Recalls who were examined				540	540
Recalls found to have active T.B.	232	228	169	198	167
Active T.B. found but previously known	65	46	34	45	34
New cases of active T.B. found	167	182	135	153	133
Cases referred to the special intrathoracic clinic at chapel street	632	351	253	361	373
Extra Municipal cases discovered	27	46	34	37	37

Table V.XII *RESULTS OF MASS MINIATURE RADIOGRAPHY AT THE LANGA X-RAY CENTRE FOR BLACK MIGRANT WORKERS : 1974 – 1976*

	1974	1975	1976
Persons examined	24 582	22 938	16 622
Recalled for further examination	1 188	714	442
New cases discovered	413	239	140
Old cases previously known	188	226	153
Particulars of those recalled for further examination.			
Old cases allowed to work under treatment	185	223	148
New cases allowed to work under treatment	367	208	112
Old cases unfit for work	3	3	5
New cases unfit for work	46	26	28
Cases found free of tubercle	587	249	149
Untraceable		69	41

N B no X-rays were taken from July to December 1976 because the Mass X-ray unit building was razed by fire during the unrest.

Table V.XIII — *HOSPITALISATION OF NOTIFIED CASES OF PULMONARY TUBERCULOSIS : 1976*

	LOCAL			Imported Cases	Outside Cape Town Cases
	City	Langa	Guguletu		
New pulmonary cases notified during the year	1 075	403	494	614	55
Known to have had T.B. positive sputum	297	137	128	170	17
New pulmonary cases admitted to institutions for treatment of tuberculosis	396	198	203	235	53
Proportion of new cases admitted	37°/o	49°/o	41°/o	38°/o	96°/o
Died before receipt of notification	16	9	11	3	1
Died within 6 months of notification	44	10	18	13	1
Pulmonary cases treated but not admitted to hospital — Male	346	116	156	252	1
Female	273	48	120	120	
TOTAL	619	164	276	372	1

Table V.XIV — *ATTENDANCES AT CITY HEALTH DEPARTMENT CENTRES FOR THE CONTROL OF TUBERCULOSIS 1975 – 1976*

	Number of sessions		New Consultations		Total Attendances	
	1975	1976	1975	1976	1975	1976
CAPE TOWN:						
White			546	416	2 405	1 885
C, A			1 291	2 187	9 077	12 457
TOTAL	173	226	1 837	2 603	11 482	14 342
WYNBERG:						
White			285	283	1 319	1 087
C, A			796	752	5 801	4 577
TOTAL	168	148	1 081	1 035	7 120	5 664
KENSINGTON: C, A	97	97	747	590	5 614	4 915
ATHLONE: C, A	102	99	664	733	5 396	4 144
SILVERTOWN: C, A	151	146	1 482	1 217	11 965	8 567
LANGA: Blacks	147	90	1 608	1 266	11 654	8 380
GUGULETU: Blacks	212	130	2 239	1 538	15 307	10 725
RETREAT: C, A	99	98	1 377	1 379	7 242	7 565
SILVERTOWN C/H: C, A	9	62	418	673	486	3 510
HEIDEVELD: C, A	46	46	501	630	2 629	3 179
LAVENDER HILL C, A		21		263		1 373
TOTALS						
White			831	699	3 724	2 972
C, A & B			11 123	11 228	75 171	69 392
All races	1 204	1 163	11 954	11 927	78 895	72 364

Table V.XV

MOBILE X-RAY UNIT WORKLOAD AT THE VARIOUS CITY HEALTH DEPARTMENT CENTRES FOR THE CONTROL OF TUBERCULOSIS : 1972 – 1976

YEAR	RACE	X-RAYS	RACE	X-RAYS	TOTAL
1972	White	1 162	C, A & B	20 759	21 921
1973	White	1 203	C, A & B	22 123	23 326
1974	White	1 417	C, A & B	28 131	29 548
1975	White	1 727	C, A & B	29 835	31 562
1976	White	1 503	C, A & B	27 962	29 465

Table V.XVI

REASONS FOR FAILURE OF NOTIFIED CASES OF PULMONARY TUBERCULOSIS TO ATTEND CITY HEALTH DEPARTMENT CLINICS : 1976

	LOCAL			Imported cases	Outside Cape Town	Total
	City	Langa	Guguletu			
Attended clinic	961	330	443	562	3	2 299
Failed to attend	140	76	63	60	52	391
	1 101	406	506	622	55	2 690
Failure to attend clinics:						
In hospital	35	18	13	22	51	139
Hospital out-patients	16		1	3		20
Too ill		1				1
Died before notification	23	7	13	5		48
First advice through death registration	12	8	8	1	1	30
Refusals	3		1			4
Under private care						
Untraceable or decamped on notification	51	42	27	29		149
TOTAL	140	76	63	60	52	391

Table V.XVII — *AMBULATORY STREPTOMYCIN INJECTIONS GIVEN AT CLINICS : 1975 – 1976*

	1975	1976
CAPE TOWN		
White	291	61
C, A & B	2 601	4 064
TOTAL	2 892	4 125
WYNBERG:		
White	76	143
C, A & B	1 042	1 043
TOTAL	1 118	1 186
KENSINGTON: C & A	2 762	2 121
ATHLONE: C & A	1 208	749
SILVERTOWN: C & A	3 604	2 945
LANGA: Blacks	14 475	13 539
GUGULETU: Blacks	17 392	13 150
RETREAT C & A	2 302	2 885
HEIDEVELD: C & A	2 138	2 551
SILVERTOWN C.H.: C & A	235	2 528
LAVENDER HILL C & A		719
TOTAL:		
White	367	204
Coloured, Asiatic and Blacks	47 759	46 294
TOTAL	48 126	46 498

Table V.XVIII — *STREPTOMYCIN USAGE AT CLINICS AND IN THE HOME : 1975 – 1976*

	1975	1976	% age change
Local and imported Notifications of Pulmonary tuberculosis	2 142	2 586	+ 20,7%
Treated at clinics only	992	1 431	+ 44,3%
Streptomycin injections at clinics	48 126	46 498	− 3,4%
Domiciliary streptomycin injections	15 258	10 417	− 31,7%
Total streptomycin injections	63 384	56 915	− 10,2%
Rate of injections of streptomycin per new clinic attendance	64	40	− 37,5%

Table V.XIX — *RESUME OF WORK DONE BY THE CARE COMMITTEE FOR TUBERCULOSIS PATIENTS : 1974 – 1976*

	1974	1975	1976
Families helped with rentals	103	82	56
Families helped with maintenance grants	379	342	325
Families helped with both of the above	85	69	86
hospital grants	277	276	364
Clothing/blankets	60	268	57
Articles of clothing distributed	223	398	241
Number of blankets distributed	30	25	25
Caseworker visits paid	710	668	335
Interviews given	1 908	2 639	2 214
New cases seen	543	498	623

Table V.XX

TOTAL LOCAL AND IMPORTED NOTIFICATIONS OF TUBERCULOSIS BY AGE, RACE AND FORM OF DISEASE : 1976

Table V.XX

	PULMONARY (INCLUDING MX POS < 5 YEARS AND MED GLANDS)					T.B.M.					OTHER					TOTAL				
	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T	W	C	A	B	T
Under 1 year	3	33		50	86		6		1	7						3	39		51	93
1 year	1	49		82	132		4		2	6		1		1	2	1	54		85	140
2 years	2	52		96	150		1		2	3				2	2	2	53		100	155
3 years		28		68	96												28		68	96
4 years	1	41		46	88		2		1	3				1	1	1	43		48	92
5 years		17		27	44				1	1				1	1		17		29	46
6 years		14		25	39							1			1		15		25	40
7 years		16		21	37							1			1		17		21	38
8 years	1	11		18	30							1			1	1	12		18	31
9 years		12		16	28												12		16	28
10 years		9		13	22		1			1							10		13	23
11 years		9		10	19							1			1		10		10	20
12 years		10		7	17				1	1							10		8	18
13 years		7		9	16												7		9	16
14 years		8		10	18												8		10	18
15 years and over	54	705	2	1 003	1 764				2	2	3	7		5	15	57	712	2	1 010	1 781
TOTAL	62	1 021	2	1 501	2 586		14		10	24	3	12		10	25	65	1 047	2	1 521	2 635
0 — 4 years	7	203		342	552		13		6	19		1		4	5	7	217		352	576
5 — 9 years	1	70		107	178				1	1		3		1	4	1	73		109	183
10 — 14 years		43		49	92		1		1	2		1			1		45		50	95
15 years and over	54	705	2	1 003	1 764				2	2	3	7		5	15	57	712	2	1 010	1 781
TOTAL	62	1 021	2	1 501	2 586		14		10	24	3	12		10	25	65	1 047	2	1 521	2 635

Table V.XXI

THE ESTIMATED PREVALENCE OF NOTIFIED TUBERCULOSIS CASES STILL REQUIRING CHEMOTHERAPY AT 1976–06–30 PER 10 000 POPULATION, BY RACE

RACE	STATUS	NOTIFIED IN 1975			NOTIFIED IN 1976			A + B/2	POPULATION MID 1976	PREVALENCE PER 10 000 POPULATION	HEAD OF POPULATION PER CASE
		PTB	OTHER	TOTAL (A)	PTB	OTHER	TOTAL (B)				
White	Local	48	8	56	54	3	57	84,5		3,3	3 030
	Imported	7	1	8	8		8				
	TOTAL	55	9	64	62	3	65	96,5	253 570	3,8	2 632
Coloured	Local	758	238	996	925	23	948	1470		30,8	325
	Imported	55	(44)	(99)	96	3	99				
	TOTAL	813	(282)	(1 095)	1 021	26	1 047	(1618,5)	477 470	33,9	295
Asian	Local	2	1	3	1		1	3,5		3,2	3 125
	Imported	4		(4)	1		1				
	TOTAL	6	(1)	(7)	2		2	(8)	11 050	7,2	1 389
Black	Local	878	244	1 122	992	15	1 007	1625,5		161,7	62
	Imported	390	(64)	(454)	509	5	514				
	TOTAL	1 268	(308)	(1 576)	1 501	20	1 521	(2336,5)	100 530	232,4	43
TOTAL	Local	1 686	491	2 177	1 972	41	2 013	3183,5		37,8	265
	Imported	456	108	564	614	8	622				
	TOTAL	2 142	599	2 741	2 586	49	2 635	4058,5	842 620	48,2	207

( ) = Estimated

Table V.XXII

SOME ESTIMATIONS OF AGE – RACE SPECIFIC INCIDENCE RATES PER 10 000 POPULATIONS OF NOTIFIED CASES OF TUBERCULOSIS (ALL FORMS, LOCAL AND IMPORTED CASES) : 1976

	1970 ESTIMATED PERCENTAGE OF CAPE TOWN POPULATION	1976 POPULATION ESTIMATED	TB ALL FORMS LOCAL AND IMPORTED	RATE PER 10 000 POPULATION
WHITE				
0 — 4 years	8,23	20 869	7	3,4
5 — 9 years	7,78	19 723	1	0,5
10 — 14 years	7,98	20 235	0	0
15 + years	76,01	192 738	57	3
All ages	100	253 570	65	2,6
COLOURED				
0 — 4 years	15,1	72 098	217	30,1
5 — 9 years	14,6	69 710	73	10,5
10 — 14 years	12,47	59 541	45	7,6
15 + years	57,83	276 121	712	25,8
All ages	100	477 470	1 047	21,9
ASIAN				
All ages	100	11 050	2	1,8
BLACK				
All ages	100	100 530	1 521	151,3

Table V.XXII

Table V.XXIII *TUBERCULOSIS MENINGITIS NOTIFICATIONS AND DEATHS (NUMBERS AND RATES), BY RACE : 1960 – 1976*

	NOTIFICATIONS								DEATHS							
	NUMBERS				RATE PER 100 000 POPULATION				NUMBERS				RATE PER 100 000 POPULATION			
	W	C & A	B	TOTAL	W	C & A	B	TOTAL	W	C & A	B	TOTAL	W	C & A	B	TOTAL
1960	6	39	7	52	3,10	14,27	10,80	9,78	x	x	x	26	x	x	x	4,89
1961	2	33	12	47	1,02	11,68	18,08	8,63	x	x	x	26	x	x	x	4,78
1962	2	19	11	32	1,01	6,49	16,17	5,73	x	x	x	15	x	x	x	2,68
1963	0	25	5	30	0	8,23	6,80	5,20	x	x	x	14	x	x	x	2,42
1964	1	28	8	37	0,49	8,89	10,88	6,26	x	x	x	11	x	x	x	1,86
1965	0	24	8	32	0	7,35	10,18	5,25	x	x	x	12	x	x	x	1,97
1966	2	11	9	22	0,97	3,25	10,12	3,47	x	x	x	16	x	x	x	2,52
1967	1	14	19	34	0,48	3,99	21,11	5,22	0	6	7	13	0	1,71	7,78	1,20
1968	1	22	12	35	0,47	6,04	14,84	5,33	0	9	6	15	0	2,47	7,42	2,28
1969	0	9	11	20	0	2,38	13,02	2,96	0	5	6	11	0	1,32	7,10	1,63
1970	1	14	11	26	0,46	3,58	12,84	3,75	0	2	3	5	0	0,51	3,50	0,72
1971	0	11	13	24	0	2,70	13,97	3,26	0	6	3	9	0	1,47	3,22	1,22
1972	0	8	13	21	0	1,89	14,26	2,79	0	7	2	9	0	1,66	2,19	1,20
1973	0	8	15	23	0	1,83	16,62	2,98	0	2	9	11	0	0,46	9,97	1,43
1974	0	8	10	18	0	1,76	10,53	2,26	2	5	9	16	0,81	1,10	9,47	2,01
1975	0	10	18	28	0	2,12	18,42	3,42	0	6	2	8	0	1,27	2,05	0,98
1976	0	14	10	24	0	2,87	9,95	2,85	0	5	6	11	0	1,02	5,97	1,31

W = White; C = Coloured; A = Asiatic; B = Blacks

x Not available

Table VI.I — NEW CASES AND TOTAL ATTENDANCES BY RACE, SEX AND DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASES : 1975 – 1976

DISEASES	1975													1976											
	NEW CASES							TOTAL ATTENDANCES						NEW CASES							TOTAL ATTENDANCES					
	White			C, A & B			Total	White			C, A & B			Total	White			C, A & B			Total	White			C, A & B			Total
	M	F	T	M	F	T		M	F	T	M	F	T		M	F	T	M	F	T		M	F	T	M	F	T	
1. Seronegative primary Syphilis	34	2	36	460	43	503	539	161	5	166	1 409	125	1 534	1 700	40	1	41	397	39	436	477	181	1	182	1 248	151	1 399	1 581
2. Seropositive primary Syphilis	57		57	617	81	698	755	261	6	267	1 789	309	2 098	2 365	42	1	43	709	69	778	821	221	1	222	2 093	335	2 428	2 650
3. Secondary Syphilis	9	4	13	171	197	368	381	31	31	62	592	1 088	1 680	1 742	10	4	14	149	156	305	319	59	19	78	547	869	1 416	1 494
4. Tertiary Syphilis				20	7	27	27				69	70	139	139				14	20	34	34		3	3	418	150	568	571
5. Latent Syphilis	15	8	23	312	1 619	1 931	1 954	132	59	191	1 519	7 543	9 062	9 253	21	7	28	337	1 664	2 001	2 029	221	34	255	1 351	7 756	9 107	9 362
6. Neurosyphilis				4		4	4				43	29	72	72				7	1	8	8				84	32	116	116
7. Congenital Syphilis (under 1 Year)				17	9	26	26	1		1	68	40	108	109				39	27	66	66				166	106	272	272
8. Congenital Syphilis (over 1 Year)				3	7	10	10				21	39	60	60				2	7	9	9	5		5	6	24	30	35
Sub Total (Syphilitic infections)	115	14	129	1 604	1 963	3 567	3 696	586	101	687	5 510	9 243	14 753	15 440	113	13	126	1 654	1 983	3 637	3 763	687	58	745	5 913	9 423	15 336	16 081
9. Gonorrhoea	207	31	238	8 142	377	8 519	8 757	489	65	554	13 088	934	14 022	14 576	226	19	245	7 734	399	8 133	8 378	505	41	546	12 029	942	12 971	13 517
10. Gonococcal vulvovaginitis					3	3	3					13	13	13					1	1	1					4	4	4
11. Gonococcal ophthalmia					10	10	10					16	16	16				3	5	8	8				16	9	25	25
Sub Total (Gonorrhoeal infections)	207	31	238	8 142	390	8 532	8 770	489	65	554	13 088	963	14 051	14 605	226	19	245	7 737	405	8 142	8 387	505	41	546	12 045	955	13 000	13 546
12. Ulcus molle				10	1	11	11	2		2	17	2	19	21	1		1	15	1	16	17	2		2	37	4	41	43
13. Lymphogranuloma venereum				3		3	3				7		7	7				2		2	2				12	1	13	13
14. Granuloma Inguinale																												
15. Venereal warts	3	3	6	81	30	111	117	4	11	15	202	132	334	349	1		1	94	39	133	134	3	1	4	229	179	408	412
16. Non-specific urethritis	62	2	64	350	4	354	418	160	3	163	678	6	684	847	48	3	51	622	8	630	681	115	6	121	1 040	18	1 058	1 179
16. Reiters syn- (a) drome				2		2	2				4		4	4				1		1	1				27		27	27
Sub Total (other venereal diseases)	65	5	70	446	35	481	551	166	14	180	908	140	1 048	1 228	50	3	53	734	48	782	835	120	7	127	1 345	202	1 547	1 674
Total V.D. Cases	387	50	437	10 192	2 388	12 580	13 017	1 241	180	1 421	19 506	10 346	29 852	31 273	389	35	424	10 125	2 436	12 561	12 985	1 312	106	1 418	19 303	10 580	29 883	31 301
17. Non-venereal	143	42	185	1 537	1 009	2 546	2 731	235	97	332	2 962	2 529	5 491	5 823	122	31	153	1 882	949	2 831	2 984	240	87	327	3 485	2 516	6 001	6 328
18. Undiagnosed								17	4	21	68	119	187	208								3		3	17	31	48	51
GRAND TOTAL	530	92	622	11 729	3 397	15 126	15 748	1 493	281	1 774	22 536	12 994	35 530	37 304	511	66	577	12 007	3 385	15 392	15 969	1 555	193	1 748	22 805	13 127	35 932	37 680

Table VI.I

Table VI.II

NEW CASES OF S.T.D. BY DIAGNOSIS, RACE GROUP AND SEX; AND INCIDENCE RATES FOR ALL FORMS OF S.T.D. TOGETHER : 1967–1976

YEAR	NEW CASES																Total	Incidence rate per 1 000 Population
	Syphilis Congenital				Syphilis Other Forms				Gonorrhoeal Infections				Other Venereal Diseases					
	W		C, A & B		W		C, A & B		W		C, A & B		W		C, A & B			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1967	1	1	47	45	64	22	1 165	1 514	152	15	3 884	401	6	1	38	8	7 364	11,8
1968		2	25	28	69	32	1 107	1 629	155	14	4 672	453	3		33	16	8 238	13,2
1969	2		23	50	48	22	816	1 936	212	30	5 244	367	21	2	48	25	8 846	13,8
1970			13	8	57	26	674	1 779	202	17	5 692	382	27	2	64	20	8 963	12,9
1971			10	14	56	12	1 264	2 130	165	24	5 672	452	41	1	111	43	9 995	13,6
1972	1		15	13	81	18	1 466	1 956	180	27	7 378	513	67	3	124	40	11 882	15,8
1973			8	13	57	15	1 604	2 287	193	17	7 905	456	65	7	157	35	12 819	16,6
1974			14	20	95	15	1 657	2 143	242	30	8 107	406	59	6	230	38	13 062	16,4
1975			20	16	115	14	1 584	1 947	207	31	8 142	390	65	5	446	35	13 017	15,9
1976			41	34	113	13	1 613	1 949	226	19	7 737	405	50	3	734	48	12 985	15,4

Table VI.III

NEW CASES OF S.T.D. IN TEENAGERS BY RACE GROUP, SEX AND DIAGNOSIS : 1976

		WHITE			C, A & B			TOTAL RACE		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Age in years	13				2	2	4	2	2	4
	14				2	3	5	2	3	5
	15				7	12	19	7	12	19
	16				40	32	72	40	32	72
	17	4		4	89	46	135	93	46	139
	18	6	2	8	175	68	243	181	70	251
	19	3	1	4	188	96	284	191	97	288
	Total	13	3	16	503	259	762	516	262	778
DIAGNOSIS	Syphilis 1—8	2	3	5	174	193	367	176	196	372
	Gonorrhoea 9—11	11		11	318	51	369	329	51	380
	Other venereal Diseases 12—16				11	15	26	11	15	26
	Total	13	3	16	503	259	762	516	262	778

Table VI.IV *NUMBER OF CASES OF CONGENITAL SYPHILIS : 1971 – 1976*

		NEW CASES		
		Male	Female	Total
1971	Under 1 Year	10	11	21
	1 Year or over		3	3
	TOTAL	10	14	24
1972	Under 1 Year	12	9	21
	1 Year or over	4	4	8
	TOTAL	16	13	29
1973	Under 1 Year	6	11	17
	1 Year or over	2	2	4
	TOTAL	8	13	21
1974	Under 1 Year	7	15	22
	1 Year or over	7	5	12
	TOTAL	14	20	34
1975	Under 1 Year	17	9	26
	1 Year or over	3	7	10
	TOTAL	20	16	36
1976	Under 1 Year	39	27	66
	1 Year or over	2	7	9
	TOTAL	41	34	75

(Only one white case was seen and this was in the over one year age group in 1972)

Table VI.V *NEW CASES AND INCIDENCE RATES BY RACE GROUP, SEX AND DIAGNOSIS (SEPARATELY) : 1975 – 1976*

	1975		1976	
	New cases	Incidence Rate	New cases	Incidence Rate
RACE:				
White	622	2,5	577	2,3
Coloured, Asiatic and Black	15 126	26,6	15 392	26,1
SEX:				
Male	12 259	30,3	12 483	30,0
Female	3 489	8,4	3 486	8,2
DISEASES:				
Syphilis	3 660	4,5	3 688	4,4
Syphilis, congenital	36	0,0	75	0,1
Gonorrhoea	8 770	10,7	8 387	10,0
Other Venereal diseases	551	0,7	835	1,0
TOTAL V.D. CASES	13 017		12 985	
Non-venereal diseases	2 731		2 984	
Undiagnosed				

Table VI.VI

NEW CASES OF, AND THE PERCENTAGE OF ALL CASES OF S.T.D. REPRESENTED BY, VENEREAL WARTS, NON-SPECIFIC URETHRITIS AND TOTAL S.T.D. OTHER THAN SYPHILIS OR GONORRHOEA BY RACE GROUP AND SEX : 1972 – 1976

	1972			1973			1974			1975			1976		
	No	°/o of total Other	°/o of total V.D.	No	°/o of total Other	°/o of total V.D.	No	°/o of total Other	°/o of total V.D.	No	°/o of total Other	°/o of total V,D.	No	°/o of total Other	°/o of total V.D.
WHITE MALE															
15 Venereal Warts	9	13,4	2,74	3	4,6	0,95	1	1,7	0,25	3	4,6	0,78	1	2,0	0,26
16 Non-Specific Urethritis	57	85,1	17,33	61	93,8	19,37	57	96,6	14,39	62	95,4	16,02	48	96,0	12,34
Total 'other' venereal disease	67	100	20,36	65	100	20,63	59	100	14,90	65	100	16,80	50	100	12,85
TOTAL S.T.D. Cases	329	—	100	315	—	100	396	—	100	387	—	100	389	—	100
WHITE FEMALE															
15 Venereal Warts				4	57,1	10,26	3	50,0	5,88	3	60,0	6,00			
16 Non-Specific Urethritis	3	100	6,25	3	42,9	7,69	3	50,0	5,88	2	40,0	4,00	3	100	8,57
Total 'other' venereal disease	3	100	6,25	7	100	17,95	6	100	11,76	5	100	10,0	3	100	8,57
TOTAL S.T.D. Cases	48	—	100	39	—	100	51	—	100	50	—	100	35	—	100
COLOURED, ASIATIC AND BLACK MALE															
15 Venereal Warts	58	46,8	0,65	69	44,0	0,71	62	27,0	0,62	81	18,2	0,79	94	12,8	0,93
16 Non-Specific Urethritis	60	48,4	0,67	80	51,0	0,83	160	69,6	1,60	350	78,5	3,43	622	84,7	6,14
Total'other' venereal disease	124	100	1,38	157	100	1,62	230	100	2,30	446	100	4,38	734	100	7,25
TOTAL S.T.D. Cases	8 983	—	100	9 674	—	100	10 008	—	100	10 192	—	100	10 125	—	100
COLOURED, ASIATIC AND BLACK FEMALE															
15 Venereal Warts	30	75,0	1,19	32	91,4	1,15	33	86,8	1,27	30	85,7	1,26	39	81,3	1,60
16 Non-Specific Urethritis	7	17,5	0,28	2	5,7	0,07	5	13,2	0,19	4	11,4	0,17	8	16,7	0,33
Total 'other' venereal disease	40	100	1,59	35	100	1,25	38	100	1,46	35	100	1,47	48	100	1,97
TOTAL S.T.D. Cases	2 522	—	100	2 791	—	100	2 607	—	100	2 388	—	100	2 436	—	100

Table VI.VI

Table VI.VII *SESSIONS HELD, NEW CASES SEEN AND TOTAL ATTENDANCES AT CLINICS : 1976*

CENTRE	SESSIONS		NEW CASES		ATTENDANCES	
	White	C, A & B	White	C, A & B	White	C, A & B
City Hospital, Portswood Road	140	203	458	1 111	1 364	2 614
Salt River	17	263	7	9 791	13	19 103
Wynberg	107	215	112	1 982	371	4 813
Kensington		58		116		418
Guguletu		18		271		965
Heideveld		95		366		1 267
Silvertown		93		627		2 720
Retreat		38		148		791
Langa		78		234		704
Lavender Hill		18		55		215
Ante-natal clinics (at Community Health Centres)				691		2 322
TOTAL	264	1 079	577	15 392	1 748	35 932

Table VI.VIII *SIDEROOM AND SPECIAL EXAMINATIONS : 1976*

	POSITIVE	NEGATIVE	TOTAL
Number of dark-ground examinations of Sp. Pall	817	53	870
Number of smear examinations of gonococci	5	—	5

In addition 7 955 blood specimens and 74 smears were sent to the Government laboratory for examination.

Table VI.IX *CONTACTS PRESENTING FOR EXAMINATION, BY RELATIONSHIP TO INDEX CASE AND DIAGNOSIS OF S.T.D. FOUND : 1976*

Contact	Total	Syphilis	Gonorrhoea	Other venereal diseases	Non venereal
Husband	22	16	4	2	
Wife	118	40	75	2	1
Friend	143	60	78	3	2
Other					
TOTAL	283	116	157	7	3

Table VII.I *ALPHABETICAL LIST OF DISEASES MADE NOTIFIABLE BY OR UNDER THE PUBLIC HEALTH ACT.*

	DISEASE	LEGISLATIVE REFERENCES
	1 Anthrax	Sec. 18(1), Act 36 of 1919
	2 Brucellosis	Sec. 18(1), Act 36 of 1919
	3 Cholera, Asiatic (F.E.D.)	Sec. 18(1), Act 36 of 1919 Sec. 37, Act 36 of 1919 and No. R.2093 of 15 November 1974
	4 Diphtheria or Membranous Croup	Sec. 18(1), Act 36 of 1919
*	5 Encephalitis, Infective	G.N. 1526 of 24 August 1920
**	6 Enteric or Typhoid Fever	Sec. 18(1), Act 36 of 1919
	7 Epidemic Cerebro-spinal Meningitis or Cerebro-spinal Fever	Sec. 18(1), Act 36 of 1919
	8 Erysipelas	Sec. 18(1), Act 36 of 1919
	9 Glanders	Sec. 18(1), Act 36 of 1919
	10 Hepatitis, Viral	R.869 of 30 May 1969
	11 Insecticides and Other Pesticides, Poisoning due to ...	R.253 of 20 February 1970
	12 Lead Poisoning..	G.N. 1752 of 25 September 1929
	13 Leprosy	Sec. 18(1), Act 36 of 1919
	14 Malaria	G.N. 2081 of 9 November 1956
	15 Ophthalmia, Gonorrhoeal	G.N. 1629 of 3 December, 1919
	Ophthalmia Neonatorum	G.N. 1629 of 3 December, 1919
	16 Plague (F.E.D.)	Sec. 18(1), Act 36 of 1919 Sec. 37, Act 36 of 1919 and No. R1827 of 22 November 1963
	17 Poliomyelitis, Acute	Sec. 18(1), Act 36 of 1919
***	18 Puerperal Fever	Sec. 18(1), Act 36 of 1919
	19 Rabies	Sec. 18(1), Act 36 of 1919
	20 Relapsing Fever	G.N. 1117 of 7 July 1944
	21 Scarlatina or Scarlet Fever	Sec. 18(1), Act 36 of 1919
	22 Sleeping Sickness or Human Trypanosomiasis (F.E.D.)	Sec. 18(1), Act 36 of 1919 Sec. 37, Act 36 of 1919 and No. R.94 of 24 January 1964
o	23 Smallpox (F.E.D.)	Sec. 18(1), Act 36 of 1919, Sec. 37, Act 36 of 1919 and No. 1826 of 22 November 1963
	24 Tetanus	G.N. 1969 of 4 December 1964
	25 Trachoma	G.N. 1577 of 14 September 1925
oo	26 Tuberculosis	Sec. 18(1), Act 36 of 1919
ooo	27 Typhus Fever (F.E.D.)	Proc. 170 of 1919 and No. R.1828 of 22 November 1963
	28 Whooping Cough	R.4368 of 28 April 1950 (locally)
	29 Yellow Fever (F.E.D.)	G.N. 1629 of 3 December 1919

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* (which term shall be deemed to mean and include Acute Encephalitis Lethargica, Acute Polio-encephalitis and all other forms of Acute Encephalitis of similar causation).

** (including Paratyphoid Fever).

*** (including septicaemia, pyaemia, septic pelvic cellulitis or other serious septic condition occurring during the puerperal state).

o (which term shall be deemed to include the form known as "amaas" or kaffir-pox and any diseases resembling small-pox, except chicken-pox).

oo (all forms of tuberculosis, except pulmonary or meningeal tuberculosis diagnosed otherwise than on the result of radiological or laboratory examination, but including tuberculosis evidenced by positive reaction to the tuberculin test in a child under the age of five years to whom B.C.G. vaccine has not been administered).

ooo (Typhus Fever was made a Formidable Epidemic Disease for the purposes of Act 36 of 1919 by this Proclamation).

(F.E.D. = Formidable Epidemic Disease, vide Secs. 37–46. Act 36 of 1919).

Table VII.II *NUMBERS OF CASES OF NOTIFIABLE DISEASES BY RACE : 1976*

	NOTIFICATIONS					DEATHS				
	White	Coloured	Asiatic	Blacks	Total	White	Coloured	Asiatic	Blacks	Total
Tuberculosis (All Forms) *	65	1 047	2	1 521	2 635	4	77		87	168
Cerebrospinal Fever	11	83		26	120	3	16		4	23
Viral Hepatitis	28	58	2	14	102		2		1	3
Scarlet Fever **	93	7			100					
Opthalmia Neonatorum		14		4	18					
Whooping Cough	1	9		5	15					
Typhoid or Enteric Fever	1	5		3	9					
Diphtheria		7		2	9				1	1
Acute Poliomyelitis		2		4	6					
Tetanus		1		1	2		1			1
Leprosy ***	1			1	2					
Puerperal Fever		1			1					
Insecticidal Poisoning	1				1					
TOTAL	201	1 234	4	1 581	3 020	7	96		93	196

* Including 622 cases of imported infection in residents of less than six months standing.

** One white case had two episodes which were both notified, i.e. 101 notifications were received and confirmed.

*** In both cases the infection was contracted elsewhere.

Table VII.III

NOTIFICATIONS OF INFECTIOUS DISEASES CLASSIFIED BY RACE GROUP AND MONTH OF NOTIFICATION : 1976

(LOCAL CASES ONLY)

PERIOD	Tuberculosis respiratory			Tuberculosis other forms			Enteric			Diphtheria			Scarlet Fever			Cerebrospinal Fever		
	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total
January	7	152	159		3	3		1	1		2	2					6	6
February	5	141	146		2	2											6	6
March	8	170	178		6	6	1	1	2								5	5
April	5	156	161	1	5	6											6	6
May	4	152	156	1	5	6										2	5	7
June	2	199	201		5	5		1	1							1	7	8
July	3	184	187		2	2							2		2	1	18	19
August	2	160	162	1	3	4		2	2				20		20	2	17	19
September	1	143	144		3	3		1	1		4	4	50	3	53	3	17	20
October	2	164	166		4	4					3	3	14	1	15	1	9	10
November	6	166	172					1	1				4	2	6	1	7	8
December	9	131	140					1	1				3	1	4		6	6
YEAR	54	1 918	1 972	3	38	41	1	8	9		9	9	93	7	100	11	109	120

PERIOD	Acute Poliomyelitis			Ophthalmia			Puerperal Fever			Tetanus			Whooping cough			Viral Hepatitis		
	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total
January		1	1		1	1										2	4	6
February					1	1								2	2	1	5	6
March		1	1		3	3								2	2	2	2	4
April														2	2		7	7
May					3	3										2	4	6
June		1	1		2	2							1		1	1	8	9
July		1	1		2	2								1	1	1	13	14
August					1	1								2	2	2	6	8
September		1	1		3	3								1	1	3	1	4
October					1	1								1	1	7	9	16
November					1	1								3	3	5	7	12
December		1	1					1	1		2	2				2	8	10
YEAR		6	6		18	18		1	1		2	2	1	14	15	28	74	102

W = White; C = Coloured; A = Asiatic; B = Blacks

Table VII.IV — NOTIFICATIONS OF INFECTIOUS DISEASES CLASSIFIED BY RACE GROUP AND AGE-GROUP : 1976

(LOCAL CASES ONLY)

AGE-GROUPS	Tuberculosis respiratory					Tuberculosis other forms					Enteric					Diphtheria				
	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total
	M	F	M	F		M	F	M	F		M	F	M	F		M	F	M	F	
Under 1 year	2	1	41	29	73			3	3	6								1		1
1 — 2 years		1	59	52	112			3	4	7								2	2	4
2 — 4 years	1	1	126	114	242			3	3	6									1	1
5 — 9 years	1		81	83	165			2	2	4			2		2			1		1
10 — 14 years			36	30	66			1	1	2			1	1	2				2	2
15 — 24 years	4	3	136	158	301		1			1				1	1					
25 — 34 years	6	2	169	104	281				4	4				3	3					
35 — 44 years	2	2	166	65	235		1	1	1	3										
45 — 54 years	10	1	168	56	235				1	1										
55 — 64 years	8		110	25	143		1	3	2	6										
65 — 74 years	5	1	34	9	49															
75 — 84 years	2		5	6	13			1		1		1			1					
85 years and over																				
Unknown	1		55	1	57															
TOTAL	42	12	1186	732	1972		3	17	21	41		1	3	5	9			4	5	9

AGE-GROUPS	Scarlet Fever					Erysipelas					Cerebrospinal Fever					Infective encephalitis				
	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total
	M	F	M	F		M	F	M	F		M	F	M	F		M	F	M	F	
Under 1 year	1			1	2								14	14	28					
1 — 2 years		3	1		4							1	5	2	8					
2 — 4 years	5	9	1	2	17						1	1	16	11	29					
5 — 9 years	26	20	1	1	48							2	12	10	24					
10 — 14 years	11	9			20						2	2	6	5	15					
15 — 24 years	2	4			6						1		3	4	8					
25 — 34 years	1	1			2								1		1					
35 — 44 years		1			1								3		4					
45 — 54 years													1		1					
55 — 64 years											1		1		2					
65 — 74 years													1		1					
75 — 84 years																				
85 years and over																				
Unknown																				
TOTAL	46	47	3	4	100						5	6	63	46	120					

AGE-GROUPS	Acute poliomyelitis					Ophthalmia					Puerperal fever					Tetanus				
	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total
	M	F	M	F		M	F	M	F		M	F	M	F		M	F	M	F	
Under 1 year			1	1	2			6	12	18								1		1
1 — 2 years			1		1															
2 — 4 years			1	2	3															
5 — 9 years																				
10 — 14 years																				
15 — 24 years																				
25 — 34 years														1	1					
35 — 44 years																				
45 — 54 years																		1	1	
55 — 64 years																				
65 — 74 years																				
75 — 84 years																				
85 years and over																				
Unknown																				
TOTAL			3	3	6			6	12	18				1	1			1	1	2

AGE-GROUPS	Leprosy					Whooping cough					Viral Hepatitis					Malaria				
	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total	W		C, A & B		Total
	M	F	M	F		M	F	M	F		M	F	M	F		M	F	M	F	
Under 1 year								7	4	11										
1 — 2 years									1	1			1		1					
2 — 4 years								1	1	2	3	2	6	6	17					
5 — 9 years						1				1		5	7	10	22					
10 — 14 years											1	1	3	9	14					
15 — 24 years											5	1	6	4	16					
25 — 34 years											4	1	6	3	14					
35 — 44 years												1	2	5	8					
45 — 54 years											3			1	4					
55 — 64 years											1		2	2	5					
65 — 74 years														1	1					
75 — 84 years																				
85 years and over																				
Unknown																				
TOTAL						1		8	6	15	17	11	33	41	102					

W = White; C = Coloured; A = Asiatic; B = Blacks

Table VII.V *NOTIFICATIONS OF INFECTIOUS DISEASES CLASSIFIED BY RACE GROUP AND WARDS, ETC : 1976*

Wards of the City etc.	Tuberculosis respiratory system			Tuberculosis other forms			Enteric Fever			Diphtheria			Scarlet Fever			Erysipelas			Cerebrospinal Fever			Infective Encephalitis		
	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total
1.		4	4										3		3									
2.	5	17	22																1		1			
3.	1	7	8				1		1				1		1				1	1	2			
4.	3	14	17										12	1	13					1	1			
5.	2	5	7										5		5				1		1			
6.		23	23								1	1								1	1			
7.		14	14		1	1																		
8.	1	62	63		1	1								2	2					6	6			
9.	9	98	107		2	2							20	1	21				3	6	9			
10.	6	3	9	1		1							5		5				1		1			
11.	4	2	6	1		1							7		7									
12.		1	1										7		7									
13.	4	1362	1366		31	31		8	8		6	6	9	2	11					78	78			
14.	7	11	18										11		11				3		3			
15.	6	18	24		1	1							4		4					1	1			
16.	3	41	44								2	2	6		6					4	4			
17.	2	202	204	1	2	3							3	1	4				1	11	12			
Not Allocated	1	34	35																					
TOTAL	54	1918	1972	3	38	41	1	8	9		9	9	93	7	100				11	109	120			
Imported Infection	8	606	614		8	8																		
Direct Removals																								
*Guguletu		500	500		10	10														15	15			
*Langa		393	393		2	2		3	3		2	2								10	10			

W = White; C = Coloured; A = Asiatic; B = Blacks
* Included in Main Table

Table VII.V Continued *NOTIFICATIONS OF INFECTIOUS DISEASES CLASSIFIED BY RACE GROUP AND WARDS, ETC. : 1976*

Wards of the City etc.	Acute Poliomyelitis			Ophthalmia			Puerperal Fever			Tetanus			Leprosy			Whooping cough			Viral Hepatitis			Malaria		
	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total	W	C, A & B	Total
1.																								
2.					1	1													1		1			
3.																			3		3			
4.																			3		3			
5.																			2		2			
6.																			1		1			
7.																								
8.																			3	4	7			
9.																1		1	3	5	8			
10.																			2		2			
11.																			1	1	2			
12.																								
13.		5	5		16	16				1	1						11	11	3	57	60			
14.																			1	1	2			
15.																			2	2	4			
16.																	1	1		1	1			
17.		1	1		1	1		1	1		1	1					2	2	3	3	6			
Not Allocated																								
TOTAL		6	6		18	18		1	1		2	2				1	14	15	28	74	102			
Imported Infection													1	1	2									
Direct Removals																								
*Guguletu		2	2		3	3											1	1		9	9			
*Langa		2	2		1	1				1	1						4	4		5	5			

W = White; C = Coloured; A = Asiatic; B = Blacks
* Included in Main Table

Table VII.VI

NOTIFICATIONS, DEATHS, INCIDENCE RATES PER 100 000 POPULATION AND DEATH RATES PER 100 000 POPULATION OF CERTAIN INFECTIOUS DISEASES BY RACE GROUP : 1967 – 1976

YEAR	CEREBROSPINAL FEVER								TYPHOID OR ENTERIC FEVER								DIPHTHERIA							
	Notifications		Deaths		Incidence rate per 100 000		Death rate per 100 000		Notifications		Deaths		Incidence rate per 100 000		Death rate per 100 000		Notifications		Deaths		Incidence rate per 100 000		Death rate per 100 000	
	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B
1967	20	267		29	9,54	60,53		6,57	3	24			1,43	5,44			2	9			0,95	2,04		
1968	13	140	2	10	6,13	31,47	0,94	2,25		10		1		2,25		0,22	1	9			0,47	2,02		
1969	8	89		9	3,73	19,26		1,95		4				0,87				11		1		2,38		0,22
1970	13	48	1	7	5,99	10,06	0,46	1,47	1	19			0,46	3,98			1	3			0,46	0,63		
1971	5	47		3	2,12	9,40		0,60	1	19		1	0,42	3,80		0,20		6				1,20		
1972	8	50		6(10)	3,35	9,74		1,95	1	16			0,42	3,12				5		1(2)		0,97		0,39
1973	5	41	1	4	2,06	7,76	0,41	0,76		10				1,89			3	3			1,24	0,57		
1974	16	74		1	6,50	13,47		0,18	1	19			0,41	3,46				5		2		0,91		0,36
1975	10	62		5	4,00	10,90		0,88		15				2,64				11		1		1,93		0,18
1976	11	109	3	20	4,34	18,50	1,18	3,40	1	8			0,39	1,36				9		1		1,53		0,17

	VIRAL HEPATITIS								INFECTIVE ENCEPHALITIS								ACUTE POLIOMYELITIS							
1967										3		3		0,68		0,68	1	2	1		0,48	0,45	0,48	
1968										1		1		0,22		0,22	1	16		1	0,48	3,60		0,22
* 1969	64	51	3	5	50,9	18,8	2,3	1,9		3		3		0,65		0,65		1				0,22		
1970	44	43	1	3	20,27	9,01	0,46	0,63	2	1	2	1	0,92	0,21	0,92	0,21		3				0,63		
1971	68	107		2	28,87	21,39		0,40										2				0,40		
1972	80	127	1(2)	1(2)	33,47	24,74	0,84	0,39									1	10			0,42	1,95		
1973	48	64	1	5	19,79	12,12	0,41	0,95		3		2		0,57		0,38		4				0,76		
1974	30	74	2	8	12,19	13,47	0,81	1,46										5				0,91		
1975	30	69	2	2	12,01	12,13	0,80	0,35										6				1,05		
1976	28	74		3	11,05	12,56		0,51										6				1,02		

* As from 30 May 1969

	SCARLET FEVER								TETANUS AND TETANUS NEONATORUM								WHOOPING COUGH							
1967	16	5			7,63	1,13				6		2		1,36		0,45	6	21		2	2,86	4,76		0,45
1968	18	8			8,49	1,80				3		1		0,67		0,22	2	22		4	0,94	4,94		0,90
1969	27	9			12,59	1,95				4		3		0,87		0,65	6	8			2,80	1,73		
1970	19	5			8,75	1,05				4				0,84			7	22		3	3,23	4,61		0,63
1971	57	10			24,20	2,00			1	3			0,42	0,60			15	17		1	6,37	3,40		0,20
1972	32	12			13,39	2,34			1	6		1	0,42	1,17		0,19	9	15		2(3)	3,76	2,92		0,58
1973	7	9			2,89	1,70				3		2		0,57		0,38	3	19		2	1,24	3,60		0,38
1974	3	5			1,22	0,91				4		1		0,73		0,18	13	24		3	5,28	4,37		0,55
1975	4	9			1,60	1,58				3		2		0,53		0,35	4	16			1,60	2,81		
1976	93	7			36,68	1,19				2		1		0,34		0,17	1	14			0,39	2,38		

Table VII.VII *CEREBROSPINAL FEVER NOTIFICATIONS BY MONTH : 1972 – 1976*

	January	February	March	April	May	June	July	August	September	October	November	December	Year
1972	8		1	2	6	5	7	7	8	6	5	3	58
1973	7	3	3	3	1	4	8	5	3	4	1	4	46
1974	3	2	2	4	3	6	13	11	14	13	14	5	90
1975	5	4	1	3	5	7	8	6	8	11	11	3	72
1976	6	6	5	6	7	8	19	19	20	10	8	6	120
TOTAL	29	15	12	18	22	30	55	48	53	44	39	21	386
Average	5,8	3	2,4	3,6	4,4	6	11	9,6	10,6	8,8	7,8	4,2	77,2

Table VII.VIII *NOTIFICATIONS RECEIVED OF NOTIFIABLE DISEASES IN MUNICIPAL RESIDENTS (INCLUDING IMPORTED INFECTIONS): 1967 – 1976*

	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Anthrax										
Brucellosis (Malta Fever)										
Cholera, (Asiatic)										
Diphtheria or Membranous croup	11	10	11	4	6	5	6	5	11	9
Encephalitis, Infective	3	1	3	3			3			
Enteric or Typhoid Fever	27	10	4	20	20	17	10	20	15	9
Epidemic Cerebrospinal Fever	287	153	97	61	52	58	42	90	72	120
Erysipelas	2	3	2	3	2	1				
Glanders										
Hepatitis, Viral			115	87	175	207	112	104	99	120
Insecticidal/Pesticidal poisoning	1					1				1
Lead Poisoning	1									
Leprosy	2	1	2		2			1		2
Malaria					1	1				
Ophthalmia Neonatorum/Gonococcal	330	261	189	123	89	32	36	50	18	18
Plague										
Poliomyelitis, Acute	3	17	1	3	2	11	4	5	6	6
Puerperal Fever	1	1		8	1	3	1	1		1
Rabies										
Relapsing Fever										
Scarlet Fever	21	26	36	24	67	44	16	8	13	100
Sleeping Sickness (Trypanosomiasis)										
Smallpox										
Tetanus	6	3	4	4	4	7	3	4	3	2
Trachoma										
Tuberculosis (all forms)	2040	2245	2127	2307	2321	2263	2516	2687	2742	2635
Typhus Fever				1						
Whooping Cough	27	24	14	29	32	24	22	37	20	15
Yellow Fever										

Table VIII.I *DAILY AVERAGE NUMBER OF BEDS OCCUPIED, BY RACE GROUP, DIAGNOSIS AND RESIDENTIAL STATUS OF THE PATIENTS : 1976*

DISEASE	FROM CAPE TOWN MUNICIPALITY		FROM OUTSIDE MUNICIPALITY	
	WHITE	C, A & B	WHITE	C, A & B
Measles	0,1	12,3	0,2	10,7
Acute poliomyelitis		1,4		4,3
Cerebrospinal fever	0,3	3,5	0,4	4,3
Diphtheria		0,5		0,3
Enteric fever	0,1	0,7		1,5
Scarlet fever				
Whooping cough	0,0	0,8	0,1	1,7
Tuberculosis, pulmonary	4,7	155,8	2,8	10,5
Tuberculosis, other forms		16,7	0,9	4,6
Leprosy				
V.D.				
Viral Hepatitis	0,0			0,0
Infective Encephalitis				
Other diseases	0,1	1,4	0,3	2,0
TOTAL	5,3	193,0	4,6	39,9

The average daily number of patients in the hospital was 243.

Table VIII.II *ADMISSIONS, DISCHARGES AND DEATHS BY RACE AND SEX : 1976*

	WHITE		COLOURED		ASIATIC		BLACK		TOTAL
	M	F	M	F	M	F	M	F	
Patients in hospital 31 December, 1975	6	4	14	59			41	108	232
Admitted	71	40	414	580			259	413	1777
Discharged	64	40	392	566			253	436	1751
Died	4		13	21			12	15	65
In hospital 31 December, 1976	9	4	23	52			35	70	193

Table VIII.III *AGE DISTRIBUTION OF PATIENTS IN THE HOSPITAL AT THE BEGINNING OF THE YEAR OR ADMITTED DURING THE YEAR : 1976*

	AGE GROUPING OF PATIENTS					
	UNDER 5 YEARS	5—14 YEARS	15—24 YEARS	25—44 YEARS	OVER 45 YEARS	TOTAL
White	31	15	10	18	47	121
Coloured	672	126	106	120	47	1071
Asiatic						
Black	497	40	83	136	61	817
TOTAL	1200	181	199	274	155	2009

Table VIII.IV *TUBERCULOSIS, PULMONARY : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
	WHITE	Male						3	6	2	8	14	4	3			40
		Female				1	1	3	2	2		1	1	1	1		13
		TOTAL				1	1	6	8	4	8	15	5	4	1		53
		Deaths									1	3					4
	COLOURED	Male	7	12	11												30
		Female	5	8	7	3	7	69	52	34	26	5	4	4		1	225
		TOTAL	12	20	18	3	7	69	52	34	26	5	4	4		1	255
		Deaths	1	1				2			3			1			8
	ASIATIC	Male															
		Female															
		TOTAL															
		Deaths															
	BLACK	Male	18	19	24	1											62
		Female	12	20	25	7	8	57	62	30	17	11	7	2	1		259
		TOTAL	30	39	49	8	8	57	62	30	17	11	7	2	1		321
		Deaths	3		1			2		1		1	1				9

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE	4	4	7	4	3	2	5	5	2	3	6	8	53
COLOURED	23	20	23	19	18	18	32	24	22	17	16	23	255
ASIATIC													
BLACK	31	23	25	26	29	32	25	28	38	16	30	18	321
TOTAL	58	47	55	49	50	52	62	57	62	36	52	49	629
DEATHS	2		4				1	7	2	2	1	2	21

Table VIII.V *TUBERCULOUS MENINGITIS : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
	WHITE	Male Female															
		TOTAL															
		Deaths															
	COLOURED	Male Female	2 4	1 1	1 2			 1									4 8
		TOTAL	6	2	3			1									12
		Deaths	1														1
	ASIATIC	Male Female															
		TOTAL															
		Deaths															
	BLACK	Male Female	2	1 2	3 1	1	 1										7 4
		TOTAL	2	3	4	1	1										11
		Deaths			1	1											2

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE													
COLOURED			1	1	5		1			1	3		12
ASIATIC													
BLACK		1	1		1	2	3	1	1		1		11
TOTAL		1	2	1	6	2	4	1	1	1	4		23
DEATHS			2						1				3

Table VIII.VI *MEASLES : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
MEASLES	WHITE	Male	3	2	2												7
		Female		1	3												4
		TOTAL	3	3	5												11
		Deaths															
	COLOURED	Male	81	63	52	6											203
		Female	53	56	51	11											172
		TOTAL	134	119	103	17											375
		Deaths	8	4	1	1											14
	ASIATIC	Male	1			1											2
		Female															
		TOTAL	1			1											2
		Deaths															
	BLACK	Male	58	51	22	2											133
		Female	47	48	9	1											105
		TOTAL	105	99	31	3											238
		Deaths	3	7													10

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE				1	1		1	1	2	3	2		11
COLOURED	16	17	23	44	38	59	40	32	29	28	27	22	375
ASIATIC							1		1				2
BLACK	8	19	20	41	43	35	24	15	12	12	5	4	238
TOTAL	24	36	43	86	82	94	66	48	44	43	34	26	626
DEATHS		2		5	6	1	4	4	1	1			24

Table VIII.VII *CEREBROSPINAL FEVER : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
CEREBROSPINAL FEVER	WHITE	Male	1		4	3	1		1							1	11
		Female		2		1	4										7
		TOTAL	1	2	4	4	5		1							1	18
		Deaths															
	COLOURED	Male	32	10	31	15	4	2	3	2			1				100
		Female	21	8	14	17	5	5	2								72
		TOTAL	53	18	45	32	9	7	5	2			1				172
		Deaths	3	1									1				5
	ASIATIC	Male															
		Female				1											1
		TOTAL				1											1
		Deaths															
	BLACK	Male	2	1	5		1	2		1	2						14
		Female	6	1	1	2		1									11
		TOTAL	8	2	6	2	1	3		1	2						25
		Deaths	1														1

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE	1			2	4	1	3	2	4		1		18
COLOURED	12	8	9	11	13	11	24	21	17	21	11	14	172
ASIATIC								1					1
BLACK		3	1	1	3	1	3	5	4	1	2	1	25
TOTAL	13	11	10	14	20	13	30	29	25	22	14	15	216
DEATHS					1		2	2			1		6

Table VIII.VIII *ACUTE POLIOMYELITIS : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
ACUTE POLIOMYELITIS	WHITE	Male Female															
		TOTAL															
		Deaths															
	COLOURED	Male Female	4	8 3	6 7	1 4	1										15 19
		TOTAL	4	11	13	5	1										34
		Deaths			1												1
	ASIATIC	Male Female															
		TOTAL															
		Deaths															
	BLACK	Male Female	2 2	1	3												2 6
		TOTAL	4	1	3												8
		Deaths															

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE													
COLOURED		1	5	1	5	8		9	5				34
ASIATIC													
BLACK	1		1		-	1	2		2			1	8
TOTAL	1	1	6	1	5	9	2	9	7			1	42
DEATHS								1					1

Table VIII.IX *TYPHOID FEVER : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
TYPHOID OR ENTERIC FEVER	WHITE	Male												1			1
		Female															
		TOTAL												1			1
		Deaths															
	COLOURED	Male			1	3		5	1				1				11
		Female		1			1	3	2	1		1					9
		TOTAL		1	1	3	1	8	3	1		1	1				20
		Deaths															
	ASIATIC	Male															
		Female															
		TOTAL															
		Deaths															
	BLACK	Male				2	1	3									6
		Female						2	1								3
		TOTAL				2	1	5	1								9
		Deaths															

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE			1										1
COLOURED		3	1	1	1	1	5		2	1	1	4	20
ASIATIC													
BLACK	1	1		1		1		1		1	1	2	9
TOTAL	1	4	2	2	1	2	5	1	2	2	2	6	30
DEATHS													

Table VIII.X *DIPHTHERIA : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
DIPHTHERIA	WHITE	Male Female															
		TOTAL															
		Deaths															
	COLOURED	Male Female	1	1 3	1	2	1 2										5 6
		TOTAL	1	4	1	2	3										11
		Deaths															
	ASIATIC	Male Female															
		TOTAL															
		Deaths															
	BLACK	Male Female		1	1												1 1
		TOTAL		1	1												2
		Deaths		1													1

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE													
COLOURED	1		1				1		5	2	1		11
ASIATIC													
BLACK	1									1			2
TOTAL	2		1				1		5	3	1		13
DEATHS	1												1

Table VIII.XI — *WHOOPING COUGH : 'AGE–RACE–SEX DISTRIBUTION OF ADMISSIONS; AND ADMISSIONS BY MONTH AND RACE' : 1976*

a) AGE-GROUPS			Under 1 year	1 year	2—4 years	5—9 years	10—14 years	15—24 years	25—34 years	35—44 years	45—54 years	55—64 years	65—74 years	75—84 years	85 years and over	Unknown	TOTAL
WHOOPING COUGH	WHITE	Male				1											1
		Female	1			1						1					3
		TOTAL	1			2						1					4
		Deaths															
	COLOURED	Male	10	1	2	1											14
		Female	11	1	1	1											14
		TOTAL	21	2	3	2											28
		Deaths	1														1
	ASIATIC	Male															
		Female															
		TOTAL															
		Deaths															
	BLACK	Male	4		1	1											6
		Female		1													1
		TOTAL	4	1	1	1											7
		Deaths															

b) PERIOD	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
WHITE			1			1		1	1				4
COLOURED	2	3	3	3	2		1	6	2	1	4	1	28
ASIATIC													
BLACK	1	1		2				1	1		1		7
TOTAL	3	4	4	5	2	1	1	8	4	1	5	1	39
DEATHS	1												1

Table VIII.XII *CLINICAL ROOM AND X-RAY DEPARTMENT ATTENDANCES AND PROCEDURES*

	WHITE	C, A & B	TOTAL
CLINICAL ROOM:			
Surgical consultations	3	119	122
Mantoux tests	16	386	402
Schick tests	3	27	30
Special injections (bronchograms)		1	1
Other injections and examinations	59	642	701
X-RAY DEPARTMENT:			
X-Rays	788	7052	7840
Bronchograms		1	1
Tomograms	5	5	10
Special X-Rays		4	4
Dental		74	74
C C C Patients	5	26	31
C D C Patients	1	13	14
C D C X-Rays	1	10	11

Table IX.I *REVENUE AND ATTENDANCES (EXCLUDING SERVICES FOR SCHOOL-CHILDREN PROVIDED ON BEHALF OF OTHER AUTHORITIES) : 1973 – 1976*

	1973	1974	1975	1976
Revenue from fees	R30 095,47	R28 663,59	R34 205,62	R42 685,37
New Attendances	26036	23124	22468	17850
Total Attendances	48313	45006	38048	36473
Number of General Sessions	2846	2736	2601	2304
Average Revenue Per Patient	R 1,16	R 1,24	R 1,52	R 2,39
Average Revenue Per Attendance	R 0,62	R 0,64	R 0,64	R 1,17
Revenue per Session	R10,57	R10,48	0,90	R18,53

Table IX.II *ATTENDANCES AND TREATMENT GIVEN, BY RACE GROUP AND CLINIC OR OTHER POINT OF CARE; ADULTS, CHILDREN AND SCHOOLCHILDREN : 1976*

CENTRE		SESSIONS	ATTENDANCES				Extractions Persons		Fillings Persons		Examinations and other Dental Treatment		DENTURES SUPPLIED			
			NEW		TOTAL								W		C, A & B	
			W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	W	C, A & B	Full	Partial	Full	Partial
Hope Street	General Adults	1542	767	6243	2474	13769	238	3532	181	197	2066	10050	172	33	665	43
	Children		387	1787	938	3463	204	1497	125	87	609	1879		2	2	
	School Children	237	137	972	444	2044	103	1561	249	62	107	422				
	TOTAL	1779	1291	9002	3856	19276	545	6590	555	346	2782	12351	172	35	667	43
Maitland	General Adults	80	17	223	21	347	5	117			22	230				
	Children		47	597	72	1150	23	582			49	598				
	School Children	42		749		805		721				84				
	TOTAL	122	64	1569	93	2302	28	1420			71	912				
Silvertown	General Adults	172		542		917		370				547				
	Children			1726		3222		1490				1732				
	School Children	106		1245		1963		1734				229				
	TOTAL	278		3513		6102		3594				2508				
Wynberg	General Adults	67	7	124	11	209	4	83			7	126				
	Children		17	316	29	609	12	266			17	343				
	School Children	84	20	692	20	1185	20	968		42		179				
	TOTAL	151	44	1132	60	2003	36	1317		42	24	648				
Retreat	General Adults	131		593		1037		402				635				
	Children			1137		2140		957				1185				
	School Children	67		767		1197		1051				146				
	TOTAL	198		2497		4374		2410				1966				
Lansdowne	General Adults	85	1	145	1	248		101			1	147				
	Children		18	672	23	1251	5	570			18	681				
	School Children	57		632		950		857		20		76				
	TOTAL	142	19	1449	24	2449	5	1528		20	19	904				
Langa	General Adults			82		199		181				18				
	Children			5		11		9				2				
	TOTAL	22		87		210		190				20				
Guguletu	General Adults			739		1380		556				824				
	Children			616		1207		541				666				
	TOTAL	112		1355		2587		1097				1490				
City Hospital	General Adults			79		144		65				79				
	Children			2		4		2				2				
	TOTAL	9		81		148		67				81				
Heideveld	General Adults			246		409		162				247				
	Children			545		1018		478				540				
	TOTAL	76		791		1427		640				787				
Dr. Stalls Sanatorium	General Adults			95		95		90				5				
	Children			10		10		9				1				
	TOTAL	7		105		105		99				6				
Maitland Cottage Homes	CHILDREN	1		65		65						65				
TOTAL	ADULTS	2304	792	9111	2507	18754	247	5659	181	197	2096	12908	172	33	665	43
	CHILDREN		469	7478	1062	14150	244	6401	125	87	693	7694		2	2	
	SCHOOL CHILDREN	593	157	5057	464	8144	123	6892	249	124	107	1136				
	TOTAL	2897	1418	21646	4033	41048	614	18952	555	408	2896	21738	172	35	667	43

Table IX.III *TRENDS IN ATTENDANCES AT DENTAL CLINICS : 1974 – 1976*

	1974			1975			1976		
	WHITE	C, A & B	L and G	WHITE	C, A & B	L and G	WHITE	C, A & B	L and G
NEW ATTENDANCES									
Schoolchildren	86	15520	1382	148	11566	1423	157	5057	621
Other Children	928	9874		730	10155		469	7478	
Adults	766	11556	2029	617	10966	2030	792	9111	821
TOTAL	1780	36950	3411	1495	32687	3453	1418	21646	1442
TOTAL ATTENDANCES									
Schoolchildren	630	22657	2292	528	16321	2095	464	8144	1218
Other Children	2414	16175		1482	14724		1062	14150	
Adults	2656	23761	3163	1895	19947	2915	2507	18754	1579
TOTAL	5700	62593	5455	3905	50992	5010	4033	41048	2797
NUMBER OF SESSIONS (all races)									
General		2736			2601			2304	
Schoolchildren		1471			1291			593	

C, A & B = Coloured, Asiatic and Black (including Langa and Guguletu).

L and G = Langa and Guguletu

Table IX.IV *ADULT BLACK/COLOURED/ASIATIC TOTAL ATTENDANCES CORRECTED FOR THE CLOSING OF LANGA AND GUGULETU CENTRES DURING 1976*

	1974	1975	1976
Total Attendances	23 761	19 947	18 754
Langa } Guguletu }	3 163	2 915	1 579
Balance	20 598	17 032	17 175

Table IX.V *TOTAL ATTENDANCES OF NON-WHITE CHILDREN (EXCLUDING COLOURED SCHOOLCHILDREN BECAUSE OF THE TAKEOVER OF RESPONSIBILITY OF THE DENTAL CARE OF THIS GROUP BY THE STATE HEALTH DEPARTMENT; BUT INCLUDING ALL BLACK CHILDREN) CORRECTED FOR THE CLOSING OF LANGA AND GUGULETU CENTRES DURING 1976*

	1974	1975	1976
Total Attendances	16 175	14 724	14 150
Langa } Guguletu }	2 292	2 095	1 218
Balance	13 883	12 629	12 932

Table IX.VI *RATES PER 1 000 NEW ATTENDANCES FOR : –*

A) Examinations or other dental treatment

B) Fillings

C) Extractions

D) Dentures

for various age – race groups : 1976

	A	B	C	D
White Adults	2646	229	312	259
White schoolchildren	682	1586	783	0
White other children	1478	267	520	4
C, A & B Adults	1417	22	621	78
C & A schoolchildren	225	25	1363	0
Black (all) and C & A (other) children	1029	12	856	0,3

Table X.I — *WASHHOUSE ATTENDANCES AND REVENUE : 1976*

	ATTENDANCES	MONEY TAKEN R C
Hout Street	721	131 76
Mowbray	1 568	2 031 40
Claremont	2 119	2 550 98
Wynberg	1 566	2 142 52
TOTAL	5 974	6 856 66

Table X.II — *ATTENDANCES AT EXAMINATION CENTRE : 1976*

Department	Total	Fit	Temporarily fit	Unfit
City Engineer	2 186	1 624	460	102
City Electrical Engineer	583	438	120	25
Town Clerk	710	524	152	34
City Treasurer	57	41	15	1
Health	37	21	14	2
TOTAL	3 573	2 648	761	164

The Department also provides medical attention for Fire Brigade and Traffic personnel.

Table X.III — *ATTENDANCES AT CLEANSING STATION : 1976*

PERSONS	FIRST ATTENDANCES						TOTAL ATTENDANCES					
	SCABIES	IMPETIGO	BODY LICE	RING WORM	HEAD LICE	TOTAL	SCABIES	IMPETIGO	BODY LICE	RING WORM	HEAD LICE	TOTAL
CHILDREN UNDER 16 YEARS OF AGE:												
White boys	7		3		56	66	7		3		58	68
White girls	4	4	9		60	77	4	4	9		60	77
C, A & B Boys	763	78			52	893	763	78			52	893
C, A & B Girls	738	97	2	1	147	985	739	97	2	1	149	988
TOTAL CHILDREN	1 512	179	14	1	315	2 021	1 513	179	14	1	319	2 026
ADULTS:												
White males	6		3			9	6		3			9
White females	2		1		3	6	2		1		3	6
C, A & B males	242	8	32			282	242	8	32			282
C, A & B females	488	6	9		3	506	488	6	9		3	506
TOTAL ADULTS	738	14	45		6	803	738	14	45		6	803
TOTAL PERSONS:												
White	19	4	16		119	158	19	4	16		121	160
Coloured Asian and Black	2 231	189	43	1	202	2 666	2 232	189	43	1	204	2 669
All races	2 250	193	59	1	321	2 824	2 251	193	59	1	325	2 829

Table XI.I — *INSPECTIONS MADE BY DISTRICT HEALTH INSPECTORS : 1976*

Bakehouses	904
Boarding houses and hotels...	598
Chalets	7606
Dairy Stables	1681
Foodshops	14595
Other shops	7156
Hawkers	1747
Horse stables and cattle premises	525
House inspections	17903
Ice cream dealers	1365
Infectious diseases	1206
Markets	2025
Milk shops	1228
Blacks vaccinated	37556
Office interviews	7826
Open land, beaches	7690
Places of entertainment	1284
Refuse tips	183
Restaurants and cafes	8568
Schools	897
Smoke and air pollution	49
Streets and lanes	3202
Vehicles	1992
Washhouses	288
Other visits	10397
TOTAL	138472

Table XI.II — *PARTICULARS IN CONNECTION WITH VISITS RECORDED IN TABLE XI.I*

Visits to premises where action was taken in connection with rodent infestation	108
Visits at which premises were disinfected	38
Drain tests carried out	106
NEW NOTICES SERVED	
Verbal notices	206
Formal written notices	1250
Total proceedings instituted	1456
Written notices following verbal notices	2
TOTAL NOTICES SERVED (including new and subsequent notices)	
Verbal notices	209
Formal written notices	1401
TOTAL NOTICES SERVED	1610

Table XI.III — *ITEMS INCLUDED IN THE 1610 NOTICES DETAILED IN TABLE XI.II, BY WARD*

	Drainage	Household	Food Premises	Stable	Other	Total
Ward 1	1	9	1		1	12
Ward 2	1	11	22		8	42
Ward 3		26	35			61
Ward 4		30	59		6	95
Ward 5		30	9		4	43
Ward 6		6	19		2	27
Ward 7			30		2	32
Ward 8	1	43	96		4	144
Ward 9		42	56		15	113
Ward 10		49	23		10	82
Ward 11		26	5		31	62
Ward 12		3	12		15	30
Ward 13		105	218	4	93	420
Ward 14		24	37		16	77
Ward 15		34	51		10	95
Ward 16		19	14		15	48
Ward 17		53	89	1	84	227
TOTAL	3	510	776	5	316	1610

Other defects were dealt with by the inspectors by reports of transmission to the City Engineer and other departments of the Corporation as follows: —

Stopped drains	468
Defective water fittings	77
Unauthorised structures	133
Undrained premises	40
Structural defects to premises	83
Other defects	132

Table XI.IV — *MAGISTRATES COURT CASES HEARD AT THE INSTANCE OF THE CITY HEALTH DEPARTMENT : 1976*

Nature of Offence	NUMBER OF CASES						Total Fines R
	Total	Suspended sentence	Fined	Cautioned	Not Guilty	Withdrawn	
Dwelling-house premises in insanitary conditions	5		3	1		1	85
Insanitary conditions or other offences at food premises							
Selling foodstuffs in contravention of the Foodstuffs, Cosmetics and Disinfectants Act	14		14				820

(In most of the cases there were two or more separate counts; the counts are not enumerated in the table. In some cases more than one person was summonsed for the same offence; if any one accused was fined or reprimanded, the case is recorded in the table accordingly notwithstanding that the other accused may have been discharged).

Table XI.V

APPROVAL FOR INSTALLATION OF FUEL BURNING APPLICATIONS : 1976

Appliances	Coal	Coke	Anthracite	H.F.O.	Old Engine Oil	Diesel	Wood	Gas	Electricity	Approvals granted as		Total number of appliances installed	Total number of certificates issued
										Retentions	Installations		
Hot Water Boilers			1			40		1		8	9	42	17
Steam Boilers	2			4		34		1		20	20	41	40
Air Heaters						10				9		10	9
Replacement of chimneys to fuel burning appliances			1	1		7					9	9	9
Ovens and stoves						17	1	2		4	13	20	17
Pizza ovens							2				2	2	2
Polony cookers						1				1		1	1
Stand-by Generators						1					1	1	1
Forges	2									2		2	2
Furnaces		1		1						2		2	2
Dryers								10		1		10	1
Incinerators						1			2		3	3	3
Coffee and chicory roasters						1					1	1	1
Other appliances, dip tanks and heat exchangers						2					2	2	2
	4	1	2	5	1	114	3	14	2	47	60	146	107
Conversion of fuel: Hot water boiler — anthracite to gas; Vegetable cooker — coal to gas; 2 Steam boilers — H.F.O. to diesel													3
													110

Table XI.V

Table XI.VI

AIR POLLUTION CONTROL INSPECTIONS CARRIED OUT AT PREMISES : 1976

	Routine Inspection	Excessive smoke emission General	In Smokeless Zones	Inspection at premises where approval for installations have been granted	Plans scrutinised	Unofficial installations	Requirements for proposed installation	Licences	Notices of installers	Notice for Nuisance
January	8	9		9			3			
February	33	5		3	1	3	2			
March	42	11		3	1	8		1		
April	61	7		5	4	5	3			
May	51	9		6	2	9	3		3	
June	56	15		8	1	4	6			
July	30	11		16	1	3	1	2	1	
August	54	14		13		4	2	7	1	
September	43	5	2	14	3	3	4	2	1	1
October	42	12		14	2		2	2	1	
November	25	3		8	2	1	2	5		
December	43	1	1	11	3			2		
TOTAL	488	102	3	110	20	40	28	21	7	1

Table XI.VI

Table XI.VII *COMPLAINTS CONCERNING AIR POLLUTION RECEIVED DURING 1976*

COMPLAINT	TELEPHONIC	WRITTEN	TOTAL
Smoke and products of combustion	35	8	43
Burning of waste material	47	—	47
Other — including petrol fumes, bitumen smells, sand-blasting, sawdust, spray painting etc.	33	1	34
			124

Table XI.VIII *DISEASED ANIMALS SLAUGHTERED AT THE ABATTOIR : 1976*

	BOVINES			CALVES			SHEEP & GOATS			PIGS		
	No. of carcases	Parts affected	Portions (weight kg)	No. of carcases	Parts affected	Portions (weight kg)	No. of carcases	Parts affected	Portions (weight kg)	No. of carcases	Parts affected	Portions (weight kg)
Degenerative & Dropsical conditions												
Emaciation	26	312		28	224		215	1720		12	96	
Fatty Degeneration		12						9334		1	6922	
Necrosis	1	401										
Oedema				1	8		4	32		1	8	
General conditions												
Anaemia												
Blood splashing							16	128				
Bruising	310	3974	28512	31	256		331	2831	3131	23	184	2264
Contamination		624			43					2	88988	
Fever	33	396		15	118		55	440		14	128	
Icterus	17	204		14	112		110	912		5	24	
Inefficient bleeding	1						4			2	16	
Immaturity				245	2004							
Multiple haemorrhage	2	24										
Mutilated							2	16		1	8	
Moribund	58	696		40	321		223	1784		63	464	
Offensive odours	5	60					1	8				
Overscolding										1	8	
Telangiectasis		2382										
Uraemia	1	12		3	22		7	56		1	8	
Infectious Diseases												
Actinomycosis		1125										
Anaplasmosis	28	334		5	38							
Caseous Lymphadenitis							500	114035	9744	2	28	
Babesiosis												
Erysipelas										37	288	
Leptospirosis												
Lumpy skin	2	24										
Tuberculosis	366	12479		2	16					18	209	12
Inflammatory conditions												
Adenitis	1	12		3	24					4	32	
Arthritis	4	48		6	48		152	1242	26	27	506	8
Cirrhosis		1950		1				22551			3257	
Dermatitis										12	80	
Enteritis	2	24		100	800					2	896	
Hepatitis							1	8				
Ketosis	8	96										
Lymphadentitis	2	24								1	8	
Mastitis	2	24					1			1	16	
Metritis	5	60					20	168		10	56	
Myotitis										1	8	
Nephritis	5	60		5	40		17	140		2	8	
Omphaloplebitis	2			31	248							
Pericarditis	23	1883		1	8		3	9152		3	1179	
Peritonitis	112	6392		10	80		49	414		91	675	
Pleuritis	28	1077		4	123		2	15357	13523	34	266	17
Pneumonia	40	1198		39	469		298	15358		186	1424	
Parasitic conditions												
Cysticerosis	49	28300		4	16					126	600	
Fascioliasis		518						2732				
C. Tenuicollis Infection								30722		8	222	
Hydatidosis					117		1	24492		1	2673	
Milkspots								25532				
Lungworm								37949				
Oesophagostomiasis												
Sarcosporidiosis	43	515			128		47	248		4	33	
Stilesia Hepatic		118						49413				
Infection												
Septic conditions												
Abscesses		20423	10							3	296	6279
Gangrene	54	648		5	24		13	120		9	98	
Pyaemia	75	1204		197	1240		182	1576		197	1518	
Septicaemia	9	108		2	16		8	64		11	97	
Toxaemia												
Neoplasms												
Melanomata												
Tumors (Others)				1			1	16				
Pigmentary conditions												
Melanosis	2	24										

Table XI.IX *SAMPLING UNDER ACT NO 54 OF 1972 : 1976*

Name of Samples	No. of Samples	Adulterated	Prosecuted	Warned	Not Guilty	Pending	Fines R
Milk	85						
Cream	62						
Mince Meat	146	9	8	1			320
Sausage	241	16	8	8			700
Polony	46	1		1			
Ice Cream	19	1		1			
Yoghourt	49						
Buttermilk	60						
Cheese	68						
Dripping	8						
Orange Juice	18						
Honey	3						
Apricot Juice	1						
Brawn	3						
Vinegar	1						
Guava Juice	4	2		2			
Ham and Tongue	3						
TOTAL	817	29	16	13			1020

Table XI.XI — *APPLICATIONS TO TRADE REPORTED ON BY THE MEDICAL OFFICER OF HEALTH : 1976*

A Applications received
B Granting of licences recommended (without conditions)
C Granting of licences recommended (subject to conditions)
D Number under item 3 later reported as having complied with conditons
E Refusal of licences recommended
F Applications withdrawn

		A	B	C	D	E	F
Under Municipal Regulations	Purveyors of Milk	34	30	4	4		
	Milk in Cartons	1	1				
	Milk in Tankers	5	3	2	2		
	Slaughterer of Poultry	2	2				
	Electrical Wiring Contractor	21	19	2	2		
	SUB TOTAL	63	55	8	8		
Under Provincial Ordinance No 15 of 1953 as amended by Ordinance 19 of 1972 (The Registration of Businesses Ordinance) — Food Premises	Accommodation Establishments	35	27	8	8		
	Bakers	13	2	11	11		
	Butchers	52	27	24	24	1	
	Cafe Keepers	342	204	135	135	2	1
	Dairy Farms	217	199	18	18		
	Dairy Shops						
	Eating Houses						
	Fish Mongers and Fish Friers	26	12	14	14		
	Food Manufacturers	9	6	3	3		
	General Dealers	1624	1123	491	491	8	2
	Hawkers	1567	836	731	731		
	Restaurants	30	13	17	17		
	Other Food Premises	197	168	27	27	2	
	SUB TOTAL	4112	2617	1479	1479	13	3
Under Provincial Ordinance No 15 of 1953 as amended by Ordinance 19 of 1972 (The Registration of Businesses Ordinance) — Non-Food Premises	Laundries and Dry Cleaners	27	11	16	16		
	Creches or Nursery Schools	20	11	7	7	2	
	Dealers in Motor Vehicles and Garages	214	148	65	65	1	
	Kennels or Pet Boarding Establishments						
	Offensive Trades						
	Places of Entertainment	293	216	77	77		
	Workshops	33	17	15	15	1	
	Other Non Food Premises	498	368	127	127	3	
	SUB TOTAL	1085	771	307	307	7	
Under Government Regulations	Mattress Makers and Upholsters	36	29	7	7		
	T O T A L	5296	3472	1801	1801	20	3

Table XI.XII *DWELLINGS COMPLETED BY THE CITY COUNCIL : 1976*

	Economic	No. of Houses	Sub-economic
Whites (Home Ownership)			
Non-Whites (Home Ownership)		558	
Albowville	3		
Bonteheuwel	232		
Malay Restoration Area...	5		
Bridgetown	2		
	242	558	

Table XI.XIII *APPLICATIONS TO DEMOLISH OR CONVERT DWELLINGS (NOT MORE THAN FIVE ROOMS) AND OTHER RESIDENTIAL PREMISES RECOMMENDED FOR APPROVAL OR APPROVED : 1976*

No. of rooms per unit	1976
1	6
2	26
3	31
4	52
5	9
SUB-TOTAL (Dwellings)	124
6	8
7	2
8	1
9	1
10	
11	
12	
13	
Multi-roomed boarding houses and hotels	1
SUB-TOTAL (Other Premises)	13

Table XI.XIV *RODENT CONTROL OPERATIONS : 1972 – 1976*

	1972	1973	1974	1975	1976
Inspections by pest control officers	5824	5597	6542	3813	3406
Inspections re rodents by other inspectors	20	44	31	334	108
Inspections re mosquitos by other inspectors	372	414	754	548	471
Visits made to lands and premises by rat-catchers:					
Re rodents	62258	58433	48741	47773	41830
Re mosquitoes	11323	13995	12150	9416	10479
Number of notices served by pest control officers:					
Verbal	12	3	2	19	16
Written	30	29	21	33	10
Number of rodents caught and destroyed:					
Brown rats	7019	7542	7024	6012	5610
Black rats	261	259	354	226	403
Gerbilles		42		1	12
Recovered after gassing operation	2057	394			
TOTAL	9337	8237	7378	6239	6025

(The figures given above as to rodents destroyed include only the number of animals whose dead bodies were actually recovered. There is no reason to doubt that many more were destroyed by the methods employed).

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